Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

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

TRANSCRIPT OF PROCEEDINGS

AT LEVEL 12, 530 COLLINS STREET, MELBOURNE
ON MONDAY 18 NOVEMBER 2019

INDEX

PROF KING: Welcome to the public hearings following the release of our report for the Productivity Commission's inquiry into improving mental health in Australia. My name is Stephen King and I'm presiding Commissioner on this inquiry. My fellow Commissioners are Julie Abramson and Harvey Whiteford. Before beginning today's proceedings I would like to acknowledge the Wurundjeri people who are the traditional custodians of the land on which we meet today, and pay my respects to the Elders of the Kulin nation, past, present and emerging. I extend this respect to all Aboriginal and Torres Strait Islander people in attendance today.

The purpose of this round of hearings is to facilitate public scrutiny of the Commission's work and to receive comments and feedback on the draft report.

This hearing in Melbourne is one of many around Australia, in all the states and territories, both capital cities and regional areas. We will then be working towards completing a final report to the government in May, having considered all the evidence presented at the hearings in submissions as well as other informal discussions. Submissions and comments to the inquiry will close on 23 January next year.

Participants and those who have registered their interest in the inquiry will automatically be advised of the final report release by government, which may be up to 25 parliamentary sitting days after completion. We like to conduct all hearings in a reasonably informal manner but I would like to remind participants that there are clear structures in our legislation for how these hearings are legally backed and a full transcript is being taken. For this reason comments from the floor cannot be taken.

The microphones that you'll see at the tables are purely for the transcript. They are not for amplification so I would ask people if they were able to speak up when providing evidence and we will try to speak up when asking questions.

The transcript taken today will be made available to participants and will be available from the Commission's website following the hearings. Submissions are also available on the website. These proceedings will be live streamed to the Commission's YouTube site. All participants who have registered to be here at this hearing confirm their understanding that they may be visible or audible online. If anyone here has queries about this or does not wish to be visible or audible online please approach one of our inquiry team members here today or feel free to leave the hearing now. Just inquiry members at the back, just pop up your hands so if people need to note you and I think Ken and Matt are outside as well.

Participants are not required to take an oath but should be truthful in their remarks. Participants are welcome to comment on issues raised in other submissions. I also ask participants to ensure that their remarks are not defamatory to other parties. Some people today will be talking from personal experience but I would ask them to refrain from naming specific individuals just to avoid the issues of both privacy or potential defamation.

You are all free to enter and exit the room as you want. If anyone needs a quite space, please feel free to exit the hearing and use the visitor's room next to the disabled toilets. If at any time you feel distressed please approach one of our staff who will assist you. We also have with us Bronwyn Williams who is available to provide psychological support and Bronwyn is

just at the back there.

In the unlikely event of an emergency requiring evacuation of this building, the exits are located directly in the hallway between here and the lifts. Upon hearing the evacuation tone please leave the building and assemble at the grassed area across at Bligh Street.

MS ABRAMSON: It's at the back.

PROF KING: At the back, good, I'm glad someone knows where Bligh Street is. Unless given an alternative assembly location by the fire wardens. Your assembly point is Enterprise Park which I think is the one down near the Yarra. If you require assistance please speak to one of our inquiry team members here today. If there any members of the press please let yourselves beknown and by our staff and - well, members of the press are more than welcome. Again, if they could behave in a manner fitting of this inquiry. I would ask people to put their mobile phones on silent before we start.

Now, our first participants today are Dr Ben Goodfellow and Associate Professor Campbell Paul and I invite them to identify themselves for the purpose of the record. Please come down here and if you can state your name and affiliation and if you're representing a party who you're representing and so on.

DR GOODFELLOW: Of course. Good morning, I'm Ben Goodfellow, an infant child and adolescent psychiatrist and psychanalyst.

ASSOC PROF PAUL: And I'm Campbell Paul. I'm an infant psychiatrist and I'm representing the Australian Association for Infant Mental Health and the World Association for Infant Mental Health.

PROF KING: Fantastic. And do you have any opening statements or remarks you'd like to make?

DR GOODFELLOW: Yes, we do, thank you. So firstly, thanks indeed for such an excellent opportunity. The Royal Commission very much underway in Victoria and now the Productivity Commission across the nation. I think there is a place for cautious optimism that will reform and changes will be possible to this system that needs it so much. Professor Paul will introduce himself further shortly.

Briefly I'll just say a little more about the areas and places that I work. As mentioned I'm an infant child and general psychiatrist and psychoanalyst. I've been a consultant and child psychiatrist at Geelong CAMHS for eight years. There my roles are as the lead for the perinatal and infant mental health service, the paediatric consultation liaison which is psychiatry within the paediatric setting from the (indistinct words) outpatients. I have quite a lot to do with child protection and also general supervision and clinical leadership for the team shared with two other psychiatrists down there.

I have a private family and (indistinct) practice here in Melbourne seeing infants, young children, teenagers and adults. I'm several years into my training as analyst with Freudian School of Melbourne. I've also been on the board of Alfred Health for five and a half years

and I'm chair of the Primary Care & Population Health Advisory Committee there and for what it's worth I also have two family members with a major mental illness.

So my comments today, and in the written submissions that I'll put forward before the end of January, are informed by these perspectives but it's important that I underline that I'm here as an individual and not representing the views of any of the groups that I work with. I think the - I was very encouraged to read the draft report, the fact that it examines not only the clinical domains but also many systemic and structural reforms that are necessary and of course the funding stems, it's very encouraging that the scope of the form is so broad.

Where I think there is an under emphasis and therefore a significant opportunity for us to put some views forward is with respect to the changes that might be helpful in mental health for very young people. The report quite explicitly in part 4 is interesting in prevention and early intervention and self-evidently prevention and early intervention couldn't start any earlier than in the perinatal period and in infancy and early childhood. . These are areas of mental health and physical health that are not as well understood in the community more broadly and within medicine and paediatrics as they could be.

Some key points that I would hope to advocate just to state them as sort of headlines terms, it would be excellent if we could move towards parity with paediatrics for the mental health care of very young children and women who are pregnant with emotional difficulties. It would be fantastic if there could be a reform of the mental health system that is akin to how we approach cancer services, that there are things that the population health and the public health level for primary prevention, not that that's necessarily possible in mental health, but something similar certainly is. And there's tremendous resources in focus on detecting and preventing as early as possible just as there is with cancer. We should aim to prevent early in life - to treat early in life and early in disorder.

With regard to some of the finances, ideally there would be an end to rationing mental health care at least to the degree that it is currently, instead we cannot just activity based but demand based funding. How those systems would work I would advocate should be driven very carefully and closely by the clinicians who will be carrying them out because they're very difficult to do in a meaningful way unless with something like surgical services which it's a different matter in terms of the funding arrangements.

I might pause at this point to leave enough times for questions, of course, and I'll hand over to Campbell Paul to make some comments briefly.

ASSOC PROF PAUL: Thanks, Ben. Obviously we enforce what you are saying. I'll maybe just introduce a little more of my background. I'm trained as a child psychiatrist, I trained in Edinburgh and the Royal Children's Hospital where I've worked over the last 39 years, I think, but in a whole range of other areas as well. I'm a Life Governor of the Queen Elizabeth Centre which is an early parenting centre here in Melbourne and I was on the board of the Queen Elizabeth Centre for many years.

We initiated the post graduate training in infant mental health through the University of Melbourne and just recently have delivered a Master's course in infant and parent mental health. As I say I worked at the Royal Children's Hospital primarily in consultation with

(indistinct words) working with sick infants of the families but also families referred by a general paediatrician by maternal and child health nurses and by Child Protection. So a bit like, Ben, I've had a fairly broad experience around mental health work with infants and their families.

I guess I'd characterise our approach to infant mental health as one which is very cross disciplinary and hopefully I think integrated within the community. Our course in infant mental health, for example, the largest group, but not he majority, but the largest group doing the course were maternal and child health nurses. They would have social work, psychiatry, child psychiatry, people from childcare sectors so infant mental health as an academic group as a broad discipline is very much (indistinct words) community based and I think that's really important because we need to do as much as we can to identify infants and their families who are vulnerable and at risk and they won't be primarily coming through psychiatric services as such so I think it's an example of mental health being embedded in community response to families who are struggling.

There's considerable epidemiological data and then I'm sort of switching back to the sort of medical mental health psychiatry model looking at the epidemiology of identifiable problems but there's considerable epidemiological data to show that young children, infants from birth through to age three and four experience similar prevalence of mental health problems as other children and adolescents. There's a long running community epidemiological study from Denmark which shows that infants and young children, zero to four, experience mental health problems at around the rate of 10-12 per cent where there's a diagnosable disorder and I think it reflects the fact that the broad community, the professional community, have found in relation to very difficult to accept to understand or acknowledge that infants and very young children can suffer significant mental health problems and this has been a longstanding issue for us to share with other professional colleagues but also with the community broadly that babies and toddlers can suffer emotionally.

People say, 'Oh, well they won't know anything until they can speak' or, for example, people are aware that there's a social smile that occurs at six weeks and parents will often still believe nothing happens in the baby's brain, in the baby's mind, in the baby's soul, before six weeks or 12 months so we see our mission as helping the broad community but also parents being able to put into words and respond to distressed infants. Rene Spitzer is a psychiatrist from Vienna after the First World War, between the two main wars, was especially focused on infant depression/infant withdrawal and through black and white film was able to demonstrate to professional colleagues how sad, depressed, withdrawn infants can become.

He suffered tremendous resistance and personal attack for bringing that information forward well into the latter part of his career which went into the seventies, 1970s, and I think it's still a big issue for us. It's very painful I think for parents and professionals to think about a baby, a toddler, as having severe emotional problems. The World Association for Infant Mental Health have produced an addendum, if you like, a supplement to the UN Charter on the rights of the child which is called the 'Rights of Infants' and we believe that infants have additional rights that are not fully covered by the UN Charter.

In particular the preservation of firm, safe secure attachments relationships, it's partly address in the UN Charter but we would really feel this is important to emphasise and we know that

there are thousands of - millions of infants and young children, pre-schoolers, who are in dire situations in refugee context around the world and they're often the last ones to receive acknowledgment and mental health input. That's probably enough of a statement but we can provide our statement on the Rights of Infants and the board of the World Association has got another document about the world wide burden of infant mental health which we're happy to submit to the inquiry if you would like.

PROF KING: Yes, that would be fantastic, yes.

DR GOODFELLOW: Something to mention very briefly, and I meant to do this when I introduced Professor Paul, is that infant mental health is something most doctors have never heard of, many psychiatrists haven't - certainly the rest of the community has a very large feel and one might think if he's somewhat of a niche specialty but that's very much not the case particularly here in Melbourne in Australia, there's a very large membership of the Australian Infant Mental Health Association and in fact Professor Paul in June next year will be taking over his president-elect of the World Infant Mental Health Association so for the following three years taking over at the World Congress which is to be held in Brisbane this year actually.

He'll be leading that organisation for the next three years so if there's one single recommendation or hope that I had for this hearing is that Professor Paul might be consulted widely by government and other leaders in the same way that there are some very senior accomplished well known psychiatrists guiding the government on youth and adult mental health policy, there's an excellent space in the 0-12 age group that Professor Paul could fill.

PROF KING: Would you like to lead off the question?

PROF WHITEFORD: Thanks, Stephen, very much for that, appreciated. So in some of the comments that you said in - you're suggesting there might be some recommendations that could be made about, relatively simple perhaps, that could make a change. If you had to make some recommendations or have us consider recommendations that could make a difference to the system that we've currently got given what you're describing as sort of the lack of attention to the, you know, infant mental health area, the perinatal area - what it would be? What could be different to make some changes in the right direction from your perspective?

DR GOODFELLOW: So it depends. Some of the simple changes that could make a difference come off - are based on the fact that, particularly if I speak from my experience in Melbourne and Victoria, most CAMHS services have relatively well-developed and well-functioning infant mental health services but it remains quite a puzzle to me why there are not more referrals made to these services and part of that is because of a lack of a general understanding and awareness within medicine, Allied Health nursing and the general community as for the place that psychiatry might hold and most of us graduate from medicine without much more of an idea of mental health other than maybe the five big diagnostic groups, something about suicide, psychosis and some of the medications. Psychiatry continues to be seen as a service of last resort and so it's only often months or years down the track when behavioural disturbance is getting right out of control and there's safety concerns people think, 'Oh, we better get the shrinks in'.

What we'd like to happen is that paediatrics, Allied Health and infant mental health work much more in tandem right near the beginning of a presentation in these fields. It's difficult to say precisely how that could happen. Part of it involves a lot more of the training and education of doctors and specialists who are not going to go on to become psychiatrists particularly in paediatrics and general practice but from my role on the board and my interest in systems work, part of the problem I think is that what we're measuring is largely not that important and we're certainly not measuring the important things across all of psychiatry but especially in child and infant psychiatry.

If we were, for example, to have KPIs measured in first instance we can leave targets for down the track once we know the patterns. If there were KPIs for paediatrics, family services, general practice, outside agencies, that measured how frequently they were contacting infant mental health services to discuss a case, something called 'a secondary consultation' which can seem informal and not particularly rigorous but is actually a very meaningful and complex intervention in itself.

PROF KING: Sorry, can I please stop you there. So if we're measuring the referrals though, the issue from what you've just said is that the people who you expect would make the referrals aren't picking up what the problem is or the need for the referral so what should they be picking up that they're not picking up that they're missing, what's the indicator to them that's missing - - -

DR GOODFELLOW: It's a great question and something that I say from to time is that the demand for infant mental health services is hidden in plain sight because the problems that these children are having are picked up, it's just that they're seen so typically as being something in the realm of just needing a bit more childcare support or they're ascribed to a family social situation and unless, you know, there's more resources for the family there's nothing we can do about it. Moving further, many of the problems, arguably all of the problems, that a child could be referred to mental health for are they present with physical symptoms so they're first seen as a medical and a paediatric problem.

PROF KING: So what would have to happen to change that? What does the system need to do differently?

DR GOODFELLOW: So I think, this is the thing, it's the clinicians and people in the community are noticing that children and families need extra help but they're not considering infant mental health as being part of the time that could be involved and so if there was a KPI, how many referrals have you made to your local infant mental service? It's one of those drivers that managers would then begin to ask their teams about. You know, or they would take up the offers that CAMHS services have to come and have say regular monthly consultations with organisations.

PROF KING: It's a fairly (indistinct) measure though I would have thought.

DR GOODFELLOW: It sure is.

PROF KING: It's basically saying, you know, you can have referrals to mental health

services for infants (indistinct words) your target by referring completely to the wrong people. Is there anything better that we can do that's actually focused on, you know, the outcomes and mental health of the relevant infants?

DR GOODFELLOW: I think to have infant mental health specialists embedded within these or working much more closely within these organisations that are already seeing these children would certainly go a long way towards that but I might see if Campbell has a response to that.

ASSOC PROF PAUL: Yes. A few perspectives on this and maybe from a positive perspective to start with. Certainly in Victoria there have been some I think really exceptional initiatives around infant mental health and that is, building on the universal maternal and child health service, there's been some very exciting and innovative things. Professor Louise Newman and colleagues established a training program for maternal and child health nurses called 'MERTIL', M-E-R-T-I-L, and it's a face to face but largely online training for all maternal and child health nurses in the States focusing on infants, trauma and mental health. So there's I think an increase in awareness amongst maternal and child health nurses, for example, who will be seeing infants and their parents on a regular program basis as part of their service so there's an awareness.

On the other hand, delivering a targeted therapeutic intervention is a problem because there are limited specialist services. So awareness is there, service delivery is minimal. One way of I think addressing that is leadership from the health department. We had for quite a while a very strong group in the mental health branch advocating and organising services around infant and perinatal mental health. At the moment that group of leaders within the bureaucracy are not there and that's a lack so leadership from the health department I think would be really helpful.

In the UK they've had similar difficulties getting acknowledgement of infant mental health and they've got some similar mental health service structural organisational things in the UK as here and a group called the 'Parent-Infant Psychotherapy UK' which has now transformed into a broader organisation aware that all CAMHS services, for example, in the UK were funded to provide service not to a team. What they did was actually was surveyed them and said, 'Are you aware that your funded to provide 0-18 services?' and I think something like two thirds to three quarters of the people said they were and another third or quarter said they didn't know that they were funded to do that. 'Do you have an actual program?' and then of the two thirds another two thirds it took about half of that group and then they asked, 'Do you have a program but you do actually see infants?' and the answer from again half of the group was 'No'. So I think a similar approach here would be really helpful, a reiteration that mental health services are funded publicly to provide service from 0-18 and to ensure that we actually do that in a rate that's proportionate to the population and which it isn't at the moment.

MS ABRAMSON: I have one really direct question which is really about stigma and the Commission - and it bears very much on what both of you have said to us. We made one recommendation about (indistinct) for emotional and social wellbeing and then of course people said to us, 'Well, you know, you're stigmatising. You're putting labels on children'; so how can we change that public perception? (Indistinct words) that you said the profession is

not yet aware that there are all these services and there are issues in very young children but also about the community so would we do there?

ASSOC PROF PAUL: And I think that's a really important one and it's to do with our language as well and we're often between a rock and a hard place. 'What's the evidence?' people say so you have to come up with some epidemiological about it which requires categorising infants and families in terms of, you know, real problems but in our clinical work we are at pains to try and minimise any sense of blame or stigma but I don't think it helps infants and parents to say, 'Well, there's not a problem' when there is and parents know that.

One mum came to our hospital, a major crisis in the family, with a toddler. In the middle of that she - there was an accident and the newborn baby was injured. The problem was it's especially intense for the parents around the toddler whose behaviour was getting increasingly difficult throughout the pregnancy. He kept punching his mum's belly saying, 'I don't want another baby'. She had to lock herself away to avoid getting angry with the toddler and to avoid him hurting her. The system response is, 'Well, that's just a toddler upset about the arrival of the new baby' but in the middle of that there's the new baby gets injured because of the distressing interactions within the family so I think we need to let the parents know that this is a serious and grave situation that needs additional resources to understand what's going on in the toddler's mind, what his experience is. Maybe he may even have an autistic problem. We need to be able to engage the parents without them feeling judged or stigmatised so that they can understand the toddler, the toddler/parent relationships and the impact that's having on them from the family.

From the paediatric context we've got a good (indistinct) that has the capacity to minimise stigma for some families to say - 'We're going to refer you to the child mental health service' and they'll say, 'Hang on, we've got a baby. We don't need to go to a mental health service' but - and I think that's where the collaboration, the enmeshment of our service within community services like maternal and child health at the Children's Hospital we have an instrumental health clinical embedded in the maternal and child health service so in two municipalities and we'd like to see it across the State. There's an instrumental health commissioner sitting in the consultation with the maternal and child health nurse so the family can see that the instrument health commissioner is a mental health trained person that doesn't have (indistinct words) and he's able to be part of a health care network that is responsive and thoughtful.

After the Second World War Donald Winnicott, psychoanalyst and paediatrician, made - the UK government was very concerned about parents losing their confidence after the war and, you know, there was immense trauma obviously and disruption in families and they asked Donald Winnicott to do series of radio broadcasts to parents about who infants are, what their role as parents is and they were really very powerful. He was a psychoanalyst talking to the ordinary people in the community and I think that's our job now to do something similar to be able to help parents see that their baby has a mind, has their own set of thoughts, feelings, intentions, desires, which can be railroaded - which can be impacted from birth injury from say an emerging autistic problem, that we can identify those problems early in life, early in the course of a problem, and without having - making parents feel that they are at fault or crazy. Intervene and help them, and I think that's where this business of being embedded in a

range of community services is so important.

The family violence work, we need to be there with family violence workers so they can understand what the toddler's experience is without making the mother feel she's driven her toddler crazy, but the toddler is depressed, withdrawn, avoidant, or has got major behavioural difficulties. If we're embedded in the services, then hopefully we can deliver something that isn't, as you say, frightening and stigmatising.

MS ABRAMSON: We would be really grateful to get a further submission from you, and if you could pay particular attention to what you talked about with us this morning, and we might come back to you as well.

MR CAMPBELL: Absolutely.

PROF KING: Particularly if you've got examples of things that have worked overseas, where we should look for programs in terms of that work, we'd be very grateful. So thank you very much, Dr Goodfellow and Professor Paul.

MR CAMPBELL: Thank you for listening. Thanks very much.

MS ABRAMSON: Thank you.

PROF KING: Excellent. Next we have Aurora Elmes and Krystian Seibert from the Centre for Social Impact, Swinburne. And again, if you just could state your names and affiliation, for the record, and then if you've got an opening statement.

MS ELMES: Sure. Thank you. So may name is Aurora Elmes. I'm a PhD candidate and Senior Research Assistant at the Centre for Social Impact, Swinburne.

MR SEIBERT: My name is Krystian Seibert and I'm an Industry Fellow at the Centre for Social Impact, Swinburne.

MS ELMES: So we will begin with an opening statement. The Centre for Social Impact, or CSI Swinburne, welcomes the opportunity to comment on the Commission's draft report on mental health. CSI Swinburne has particular expertise in particular expertise in social enterprise research, and social enterprises are businesses that trade to intentionally tackle social problems, and reinvest the majority of their profits back into their social mission.

A report on Finding Australia's Social Enterprise Sector notes that in 2016 there were around 20,000 social enterprises in Australia, and creating meaningful employment opportunities was the primary social purpose in just over a third of surveyed cases. Particularly relevant to this inquiry is the role of work integration social enterprise, and WISE is a social enterprise with a core purpose of providing employment opportunities to those who experience disadvantage in accessing employment, and this includes people with mental illness.

In response to the draft report recommendations on social participation and inclusion, we note that in s.20 of the draft report, the Commission highlights the relationships between socioeconomic disadvantage, stigmatising attitudes, and social exclusion of people with

mental illness. The report notes that social participation and inclusion are important to recovery, and reduce the risk of relapse. The Commission observes that work can benefit mental health and offer opportunities for social interaction, but identifies weaknesses within both the current employment services and psychosocial support systems.

There is a growing body of international research suggesting that WISEs address diverse forms of social exclusion by providing employment, increasing people's income and living standards, and providing opportunities for social connection and improved mental health and emotional wellbeing. WISE is a work integration social enterprises that involve meaningful interactions between people with and without mental illness. They also have the potential to reduce stigma, which we note is an aim of draft recommendation 20.1.

Section 20.2 of the draft report includes three pages on social enterprises as a possible pathway for promoting social participation and inclusion, but the report stops short of making any related recommendations for s.20.2. We wondered if there is any further information the Commission needs to consider recommendations for this reform area. I'll just continue on, and then I'll leave plenty of time for questions.

So alongside social participation, employment has been a key focus area of the draft report, and in response to the draft report recommendations on increasing participation in work, we note that draft recommendation 14.3 suggests further rollout of Individual Placement and Support, or IPS programs, to support people with mental illness into employment. While several evidence reviews have found IPS to be more effective than other vocational rehabilitation programs, a recent randomised control trial comparing a social enterprise with IPS found that social enterprise was similarly effective in generating positive employment, mental health, and housing outcomes.

Draft recommendation 14.3 states that, 'Government should thoroughly trial and evaluate the IPS program.' And recommendation 22.5 notes the need to build a stronger evaluation culture. We support these recommendations for ongoing evaluation, and believe there's enough evidence to consider recommending further comparative evaluation of WISE outcomes. We encourage the Commission to consider making specific recommendations for s.20.2, about what government can do to support social participation and inclusion, and to consider further evaluation of WISE as a way to facilitate employment and support social inclusion for people with mental illness. Thank you.

MR SEIBERT: And I don't have anything further to add.

PROF KING: Yes.

MS ABRAMSON: I'd like to know what you think those recommendations could be.

MS ELMES: Yes. So I was interested, because the report does go into quite a lot of detail about potential approaches to supporting social inclusion, and I did note that there is an associated recommendation 20.2, but that specifically refers to increasing access to insurance for people with mental illness. So having, you know, looked at the comments that the report has made, it's clear that while it's recognised that there's a role for psychosocial support

services and, in chapter 12, there's some detail around trying to address some issues around NDIS access, or access to psychosocial support for people who aren't eligible for NDIS.

There's evidence in terms of social inclusion that not only formal services are needed, but opportunities are needed for people to have spaces that they can go where they feel accepted, that they're able to form organic social relationships and have opportunities to build friendships. And so, part of that, I guess, our work does focus on social enterprise and work integration, social enterprise.

Part of that is looking at what organisations within the community can do to provide those spaces, and that may go potentially beyond more traditional formal support services to looking at where else people can be offered that opportunity to go and have a place to connect and be accepted and participate in a way that's meaningful to them.

MS ABRAMSON: Could I ask a follow up question? In terms of who might drive that particular outcome, are you thinking about NGOs, or are you thinking about local government?

MS ELMES: So I think there's a part to play for a number of different organisations. Our work does focus on social enterprise, so essentially, they are sort of trading organisations that have a social purpose. But I think there's a part to play across a range of different organisations. With a complex issue like this, it's not just about one actor playing their part, I think it is about the whole of community approach, and potentially with social enterprises forming one part of that.

But I think one of the key recommendations or key things that we'd like the Commission to consider is, I guess, continuing to build the evidence around what are the effective approaches. Because having looked at the social inclusion sections of the report, and having read some reviews on what is effective in terms of social inclusion for people with mental illness, there actually seems to be a little bit of a lack in evidence, and I think there's an opportunity to build more of that in terms of both evaluating IPS approaches and comparing what are the effective - the outcomes of effective work integration social enterprises.

But then perhaps also going back to look at the research literature and see if there are areas that need to have more evidence built around what's effective.

MR SEIBERT: And just to add to that, I think, like with any complex problem, it involves a multi-sectoral approach, and if we look at the case study of Vanguard Laundry, which Aurora is leading the evaluation of, it's - it itself is a charity, a public benevolent institution, but the funding it received to establish itself, it received philanthropic support, it received government funding, from both the Federal government, and I think from - did it receive state government as well?

MS ELMES: No. Just Federal.

MR SEIBERT: From the Federal government. But then, in terms of getting an anchor client in order to provide it with sort of that sort of initial kind of contract to be able to get

itself going, that was a hospital provider. So there really is sort of a multi-sectoral approach, coordinated approach.

PROF KING: Sorry, just a clarification question. You mentioned a recent publication comparing WISE, the planning of WISE, has similar results to IPS. Is that the Kirsten - sorry, Kristin Ferguson - - -

MS ELMES: Yes, that's right. So as far as I'm aware, there's only so far been that one randomised control study that does look at social enterprise and IPS approaches. It found that after, I think, a period of 22 weeks, participants in the social enterprise arm had 39 - 39 per cent of them had had any paid employment in that time compared to IPS; I think it was around 30 or 32 per cent.

So what that research has recommended is they've said, because it is a small study, it's a initial randomised control trial, there is a need for further evidence to look at - to really build a strong evidence base for that. But I think because it's - at this stage, there's very little evidence on that, and it is inconclusive, and we're aware of these outcomes that WISE can have in terms of giving people an opportunity to feel capable, to hold valued social roles, to connect with others.

We do believe there's an argument for essentially continuing to monitor the social enterprises that are in existence already, and potentially try and aggregate some more of that evidence, or look at whether there are situations in which potentially a social enterprise could be a good fit for a community of they are needing a particular service, or there's a gap in the market, or there's a need for people to have a place to gather, compared to other sort of more intermediary approaches that - like IPS that look at what are the jobs that are there, and how can we fit people into those jobs.

MS ABRAMSON: And could I ask two things? First of all, we'd really - as we said with the previous speakers - really welcome a further submission from you, particularly around work integration, social enterprise, and costs and benefits. And also, could you tell me, does the IPS model and the social enterprise, is it the same cohort of people that they're looking to support? Or are there some differences?

MS ELMES: There may be some differences. So I think, you know, like any group of people, people with mental illness are very diverse.

MS ABRAMSON: Very diverse, yes.

MS ELMES: And so I can speak, for example, from the perspective of having done the research with Vanguard Laundry Services, the group of people that they're working with, I think for IPS, there's a chance that people who do sort of put their hand up to be part of an employment support, or employment services program like that, are potentially people who are closer to the open labour market already.

MS ABRAMSON: Yes, yes.

MS ELMES: They're sort of motivated, they're looking for work, they may - potentially may have more readiness to undertake that, or more confidence to undertake that. A group, for example, like Vanguard Laundry Services is more mixed in terms of supporting people into employment who may have never worked before, may have been out of work for 20 plus years, may have been told that they can't work because of their mental illness.

And I think that - I think in those cases, potentially there can be a place for work integration, social enterprise as being an environment that is specifically set up to support people, and understands the issues that people my face, and is able to support people, whatever stage they're at. Whereas, you know, we don't know, I think, at this stage whether IPS can be as successful, because there's just not evidence at the moment. So I think it's about understanding that.

MS ABRAMSON: Well, thank you so much for your evidence today, because it's really a really interesting area, and we'd really welcome very strongly some - a written submission from you.

MS ELMES: Thank you.

PROF KING: Harvey, have you got a - - -

PROF WHITEFORD: No, no, no, it's been covered. Thank you.

PROF KING: And so, just to make sure we've got the Kristen Ferguson paper, if you could just - - -

MS ELMES: Yes. Sure.

PROF KING: **- - -** shoot through the exact reference, that would be great.

MS ELMES: Absolutely. Thank you for your time.

PROF KING: Thank you very much.

MR SEIBERT: Thank you.

PROF KING: Thanks very much. Next, we have Jade Chandler. Thank you. Thanks, Jade. And again, if you could state your name, if you are representing any particular body, which body, and if you have an opening statement.

MS CHANDLER: Great. So, my name is Jade Chandler. I'm a mental health nurse, and my role at the Australian Nursing and Midwifery Federation, the big branch, is Mental Health Nursing Officer. So my role is to represent the mental health nurse workforce across the state, and I would like to make some points in regards to the draft report. Thank you very much for the opportunity.

So we would like to thank the draft report in regards to identifying that there is a greater scope in regards to the role of the mental health nurse across the whole workforce, and not

just in hospitals, as well as mental health peer workers. I wanted to touch on some early intervention, because we'll scope in a little bit about stigma today, and identify some of the workforce that is already there and able to be potentially expanded.

So one of those is the maternal child health nurse program. So, as we know, the maternal child health nurses, whether they're the universal or the enhanced, maternal child health nurse have the capacity to do those 10 visits between birth and school age. So I think by adding in some mental health screening in regards to that, that could identify opportunities early in regards to following up on any flags, as well as at school age. So we've got the school nurse program.

So, at the moment, it is mostly general nurses. However, there's an opportunity to expand to mental health nurses, so that would be both in primary schools and secondary schools. Identified in the draft report is the need for wellbeing leaders in schools. I think nurses have that specialty. We don't want to give more teachers - or teachers more work to do. We want to be supporting teachers in what they do, and by having mental health nurses in schools, it helps that conversation, that prevention, and building, I guess, resilience in regards to that.

So these are models that are already there. In regards to the education of mental health nurses, I note that the - there's a recommendation in regards to an undergraduate mental health degree. It is the branch's position that the postgraduate model is better. It works well at the moment. I note that there's a comparison in regards to midwifery, which is in Victoria. I think that, as we've spoken again today, there is a stigma around mental health that doesn't really allow the capacity to have that attraction that a midwifery direct entry course has.

I can tell you from my personal experience, I didn't have a lot of exposure to mental ill-health until I was into my second year of nursing, and it wasn't until - excuse me - I participated in an undergraduate placement in mental health that I really sparked interest, and I think that that is the case for a lot of nurses, that they don't have that exposure, and it's not until they work, whether it's in community mental health, or an in-patient unit that they understand the work that mental health nurses do, and it sparks interest.

I also think that the three year nursing bachelor followed by the postgraduate qualification in mental health, it gives the mental health nurses the ability to provide that holistic care and have that - both the physical expertise in regards to the physical health, as well as mental health, and it gives us the edge on other workers, I think. So I wouldn't want to have that watered down.

In regards to other opportunities, I think that a lot of organisations have made submissions in regards to the Mental Health Nurse Incentive Program, which was a successful program, cost-effective, it was evaluated to be quite strong, and unfortunately, the funding was lapsed many years ago. The benefit of that program was that the nurses working in the community in a less intrusive environment were able to work long-term, so up to two years, with consumers, both their physical health as well as their mental health. So I think that that really needs to come back.

The final thing that I would like to suggest is, I note in the report there's themes in regards to access and navigation of mental health services. One opportunity, and this is something that

the branch has put into the - submission into the Royal Commission into Victoria's Mental Health Services, is to adopt the Queensland Health model of Nurse Navigators, which has the capacity of, I guess, creating that partnership with the client, providing a central point of communication and coordination for the clients and their families, as well as coordinating that timely access.

Because we all know that, at the moment, it's such a difficult service to navigate if you don't it, if you haven't had that experience working in it. So that would be a suggestion as well. And I think that's it.

PROF KING: Harvey.

PROF WHITEFORD: I'll just take you back to the question about undergraduate versus postgraduate is obviously a tricky area. Could the two co-exist or is that going to create problems within the nursing profession or for employers or consumers/families?

MS CHANDLER: I think it has the potential to create a divide in the workplace so there already is a divide in regards to the support of it, the undergraduate model and the benefits of the postgraduate model. There's also already a divide in regards to the credentialing which is a voluntary process and not required in regards to industrially or registration. There's already tiers in nursing as well with the enrolled nurse and the registered nurse. I think that it is the potential to divide the workforce even further.

PROF WHITEFORD: Can I (indistinct words) we might be jumping around topics a little bit.

MS CHANDLER: No, that's fine.

PROF WHITEFORD: The maternal child health nurses. To what degree would they need additional - well, so you've said include or you suggested that maybe it could include mental health screening in there, would that require additional training? Would that require a change in training? How do you see that being implemented on the ground?

MS CHANDLER: I think that there would be at least initially minimal training in regards to the screening process and then in regards to follow-up from that, so whether they're referred to the enhanced maternal child health nurses who already have that complex ability to look after complex families that may or may not have mental health issues or at risk of mental health issues so it might be that that screening highlights that area or that need earlier than is later highlighted. It could be that there's more enhanced maternal child health nurses because they already do a lot of great work with families with or at risk of mental health issues.

PROF WHITEFORD: Yes, okay. Now, that's sensible.

MS ABRAMSON: I feel like I keep asking questions of all the participants about stigma but you did mention that for many nurses it's not seen as an attractive career option and I'm just really interested in any ideas you have as to how we could make it a more attractive proposal because you noted in our report that we're very strongly of the view that we'd like to see more mental health nurses.

MS CHANDLER: Yes. I think that at the moment the mental health nurse workforce struggles with a lot of occupational violence and aggression and that is often seen in the media which has, you know, the capacity to put any potential nurse off so we need to fix that and that's something that unions/workplaces are trying to do and it takes a lot of time. I think that often again addressing - it's a little bit difficult - addressing the school age and university aged through - I guess some type of mental health promotion? Yes, I don't really have a whole - it's a big thing stigma and I don't really have an easy answer for you that would - - -

MS ABRAMSON: We'd encourage you, I guess, if you're making another submission.

MS CHANDLER: Yes.

MS ABRAMSON: Perhaps you could speak to the member and we'd some thoughts on that.

MS CHANDLER: Yes, of course, yes.

PROF KING: Can I just follow up on that because one of the reasons why - we've got the draft recommendations suggesting that alternative undergraduate (indistinct), we have feedback about stigma as part of the training process, in other words where the undergraduate degree of nursing there was a view put forward to the students, and I'm not saying this is all programs, but it was certainly put to us that it's certainly through some programs, students were told, 'Well, you don't want become a mental health nurse, you need to be a real nurse. If you're thinking of doing that do real nursing' and very much - so there was a stigma, a professional stigma, as part of the training which is why we perhaps thought separating that off would help but now obviously you've got different views on that. But I'd be interested in your views on that, the stigma during training.

MS CHANDLER: Yes, yes. Obviously there are some universities that are better than others in regards to that academic view as well as even entering the grad program, that can be in the workplace as well so it's definitely a hurdle. One thing that we're trying to encourage is, I guess, transition to mental health so for those nurses that were maybe discouraged from going straight into mental health, they have felt like they've lost their opportunity that they've got that opportunity to go and spend 12 months whether they're enrolled nurse or a registered nurse in a mental health to experience it and see if that's what they want to do so that's just something to address the result of that, how to prevent that is maybe just making sure we've got the right academics teaching them into health units as well.

PROF KING: Do you think there should be or there could be curriculum changes in young graduate nursing degree (indistinct words)?

MS CHANDLER: Potentially but I guess it's a fine balance in regards to, you know, we want to have the physical skills in regards to providing that holistic care so we don't want to take away from that but we don't want to have the right mental health unit, I guess, educated so it's a fine line. I think it's probably the quality of the placements because we know there's so many students looking for mental health placements so an inpatient unit is great in regards to experience that but some might be able to do the same in the community and see a

different type of mental health because the acute end is not what every nurse wants to do so there's (indistinct words) spectrum in regards to that.

PROF KING: Thank you for that.

MS ABRAMSON: Thank you.

PROF WHITEFORD: Thank you.

MS CHANDLER: Thanks

PROF KING: Next we have Associate Professor Alan Young. And again if you could state your name, affiliation and if you have any opening remarks.

ASSOC PROF YOUNG: Sure, thank you. So my name is Associate Professor Alan Young. I work as a sleep and respiratory physical here at Eastern Health in Melbourne in a public system but I'm here today with my hat on as president of the Australasian Sleep Association and I do have an opening statement if you actually have time to hear that, thank you. So first of all thank you very much for the opportunity to present at this public hearing today and also I want to commend the Commission for the sort of comprehensive report (indistinct words) innovative reforms to improve the mental health and wellbeing of the Australian population.

In advance I forwarded two documents so the first is the ASA submission to the Commission which is submission 96 which is a document, a 13 page document, with about 50 references and it highlights a large body of scientific evidence linking mental health to sleep loss and sleep disorders and this may have relevance to the report because it outlines sleep disturbance and sleep disorders as risk factors for the development of mental health disorders and importantly avenues for cost effective early intervention and treatment to prevent the development of mental health disorders.

The second document that I've forwarded was the parliamentary inquiry into sleep health awareness which is called 'Bedtime Reading' so I'll refer to it as 'Bedtime Reading'. This was recently handed down, it's a new development in April 2019. It was called the Federal Health Minister, Greg Hunt, as a standing committee on health, aged care and sport chaired by MP Trent Zimmerman carried out the report. It's completed, it received over 130 submissions and has bipartisan support and it has 11 recommendations for improving sleep health in Australia and the first recommendation is sleep is recognised as a national health priority as a third pillar of good health along with diet and exercise and two quick stats from that report: 'Four out of ten Australians are not getting the sleep they need with an annual cost to the economy of $66b'.

There are three further key recommendations that the ASA and our sister organisation, the Sleep Health Foundation, are working to have implemented which has relevant to the current Commission report, synergies with the current recommendations from the mental health report, specifically in the areas of early intervention, prevention and workplace safety. In terms of my search of the current report I couldn't, current mental health product, I could find

no reference to 'sleep/health' within that or the ASA submission but there is a consistent reference to the word 'sleep' in the section on 'homelessness' in relation to sleeping rough.

So in the interests of time I'm just going to briefly mention three areas that highlight that mention health and sleep are inextricably linked with a complex bidirectional relationship between mental health and sleep. So the first is insomnia and depression so I've reference all of the following comments: so insomnia affects up to 10 per cent of the adult Australian population and is a significant predictor for the development of depression so recent meta-analysis showed there's an odds ratio of developing depression in those with insomnia.

And depressed patients with insomnia have a worse response to treatment with higher relapse rates and depression also predicts the future risk of insomnia so that's bidirectional. So the goal standard treatment for insomnia, which is cognitive behavioural therapy, is evidence based and cost effective yet only 5 per cent of patients presenting to GPs receive this appropriate treatment and 90 per cent receive a sedative prescription, that's evidenced from the BEACH reports which is probably inappropriate first line therapy for insomnia.

So in patients with insomnia and depression CBT is as effective as antidepressant medication for treating depression, and all of these I've listed references - if you want me to quote them or I quote them from either Cunningham or Shapiro 2018, early detection and treatment of insomnia with or without comorbid depression then is likely to have a significant impact on reducing the burden of disease related to depression'. So that's one key area I wanted to highlight.

The second is sleep loss in children and adolescents. So poor sleep is linked to 'poorer current and future mental health, that's a quote from the Vic Health Promotion Foundation, 'adolescents are well recognised to have delayed sleep phase' so their body clock is delayed, their (indistinct words) is delayed, they go to bed later and get up later and of course it's an intrinsic physiological problem and they have social pressures related to bedtime where there have some sort of electronic devices so 10 to 30 per cent of adolescents have sleep problems.

And sleep interventions in school can improve sleep and mental wellbeing and I've got a quote there; Patterson behavioural sleep medicine 2017. Additionally poor sleep is a risk factor for suicide. A recent systematic review sleep disturbance was associated with increased impulsivity and increased risk of unplanned suicidal behaviour. The reference is Porras-Segovia 2019. And I've got a couple of quotes from the National Mental Health Commission and their quotes are taken from the 'Bedtime Reading' report. They stated, I'll quote:

> *Clear and compelling that indicate the close link between sleep health and mental health and explained that sleep deprivation can further contribute to the development of mental illness by lowering an individual's resilience to respond to mental health problems.*

They went on to draw attention to research indicating, and I'll quote:

> *A strong correlation between sleep disturbances and suicidal ideation and behaviour and they cited a 2017 study which found that "sleep problems worsened suicidal thoughts in the days and weeks preceding a suicide attempt or suicide completion and they added that*

complaints about sleep may serve as a warning sign and key risk factor while providing an avenue for early intervention and prevention

So those quotes are taken from the Bedtime Read report, p.20. And then the final area I'll quickly mention is the relationship between work, sleep and mental health. So longer working hours associated with poorer sleep and increased symptoms of depression and anxiety: 10-15 per cent of Australians are shift workers, often safety critical occupations such as emergency workers, working in health, commercial drivers; sleep loss and circadian misalignment resulting in shift work sleep disorder characterised by work accidents, lowered mood, anxiety and increased cardiovascular risks and standardised appropriate work hours are critical to maintain mental health and the reference for that is Alfonso, occupational medicine 2017.

So I noted with interest the Commission report in s.19.2 talked about psychological health and safety in the workplace and so workplace health and safety laws employ a code of practice in return to work, are areas I think have overlapped with sleep. So just in closing, in terms of suggestions if you're happy to hear them. A suggestion would be that potentially the report could recognise the importance of sleep loss and sleep disorders such as insomnia as a significant risk factor for the development of mental health disorders and I noted those were covered in Volume 1, the risk factors for mental health disorders.

The second suggestion is the education and intervention program in the step care model which runs across from patient self-help to lower level intervention to the psychologist specialist, could include education about sleep loss and sleep disorders at all those levels from patient all the way up to specialists and I quoted some - you know, the issues with GP education and training of psychologists in sleep. The third suggestion is that the early intervention recommendation for schools could include sleep education for teachers and students and asking about sleep-related problems.

And then the second last suggestion I think is there's synergies between the parliamentary inquiry report into sleep so I just wanted to mention three recommendations which I think could be helpful. So the first is we've currently applied for government funding for three of these recommendations: national public behavioural change campaign to improve sleep health awareness'. I think public awareness of sleep would be very helpful. That's recommendation eight.

There's also application for primary care practitioner education program related to sleep health. That includes GPs, nurses, psychologists and pharmacists, that's recommendation nine. And also within the report there's workplace safety guidelines to have standardised working hours and shift work safety guidelines that are Australia wide and that's recommendation two and three within the inquiry and I don't know if it's within the scope of the reports to look at recommendations from other reports and sort of - - -

MS ABRAMSON: Absolutely.

PROF KING: Yes.

ASSOC PROF YOUNG: That would be extremely helpful because I think there's synergies there. And then the final suggestion is ongoing training and funding for psychologists and in sleep disorders and with improved access for CBT-I such as, an example, the NHS in the UK now has since 2018 a program with online access to CBT-I. So sorry to take that long but that's my - - -

MS ABRAMSON: No, no, that's very helpful.

PROF KING: Very good. And in fact you've sort of cut off my initial question at the pass so thank you very much for that by referring to a number of recommendations of that parliamentary inquiry. I did want to - what you didn't mention was recommendation four which talks about the barriers to accessing cognitive behavioural therapy for insomnia which will review the MBS to see if it's (indistinct). Do you know if work is progressing in that area?

ASSOC PROF YOUNG: Look the stage, with my ASA hat on, the first two recommendations - because we're taking them step-wise rather than trying to get all 11 recommendations simultaneously through so we focused on the behavioural change campaign really and primary care education but within the primary care education is for further education of psychologists but we haven't gone down the MBS (indistinct words) but we will be making our way through all of those recommendations and there's some work being done with NHMRC (CRE) on alertness and productivity into the shift work issues and national standardisation.

PROF KING: And just before I pass over to my colleagues. You mentioned the I-CBT - I think you mentioned in the UK?

ASSOC PROF YOUNG: Yes, yes, so the NHS. (Indistinct words) in NHS since 2018. They've put a priority in having availability of psychological services which includes, you know, greater access to CBT for insomnia and one of the things they've implemented is - because there are online CBT-I programs available but for a cost and so they've now provided for free online CBT to certain sections of the population.

PROF WHITEFORD: Okay. Do you know if any of the ones related to sleep are embedded into broader online programs - you'll notice one of our recommendations is the expansion of online moderated mental health inventions, I don't know if you call them CBT-2, because they're broader than that.

ASSOC PROF YOUNG: Yes, because it goes much higher than that actually.

PROF WHITEFORD: Do you know if any of the sleep-related ones are embedded in those broader programs or are they (indistinct words) standard one?

ASSOC PROF YOUNG: Look, within Australia because ASA we have a role in providing sleep education, that's one of our main roles we we've got programs set up with the Royal Australian College of GPs so we've got sleep modules, which are CME accredited to look at, and one of them is on insomnia.

PROF WHITEFORD: Yes.

ASSOC PROF YOUNG: We've also got with the Australian Psychological Society there's a sleep certificate in sleep medicine, a several hour training module with the APS so we do already have the beginnings of some of the sleep education tools but our funding asks for the primary care is to roll those out. You know, we can reach 600 GPs every two or three years using the RACGP and we need to reach 10,000 GPs so that's where we'd - you know, any assistance or, you know, in terms of promotion broader reach of those education programs for GPs, psychologists, would be very helpful and appreciated.

PROF KING: Lovely. Do you have - - -

PROF WHITEFORD: I think that was a very good presentation actually so the online CBT that is in the sort of I guess the mainstream of mental health so treatment where the target is to treat, you know, common anxiety and depression as far as you're aware those programs don't have the sleep component built in the sleep (indistinct words).

ASSOC PROF YOUNG: That's a good question. I'd have to check with one of my colleagues and I think later on in Tasmania my colleague who's the President of the Sleep Health Foundation works very closely in that area with a psychologist background so she may be able to answer that question specific. I suspect there will be a sleep component but certainly not the comprehensive level that you need to achieve, yes.

PROF WHITEFORD: Sorry, so a recommendation to enhance that would be a way of (indistinct words).

ASSOC PROF YOUNG: Absolutely and I'm not sure what the Commission has planned in terms of your - because I read about your plans for online programs and I'm not sure what's in that so whether that has a - so that's one of my points just to make sure there's a basic sleep component in that so that - because it's so closely linked into ask about sleep problems and to, you know, implement measures for sleep probably appropriate as needed but the other programs I referred to are purely just CBT for insomnia, they're standalone.

PROF WHITEFORD: So I guess my perspective coming from my training is that the sleep problems are secondary to the mental problems but what you are highlighting is that the sleep problems can come first and be risk factors for them and you've got to cover both.

ASSOC PROF YOUNG: Yes so all of - and I'll forward you all the references but, you know, these are all recent references so the concept now is it's bidirectional. It's not, it's the converge of the other and so, yes, insomnia can precede the development of depression and so intervening early is clearly a way to prevent mental health illness.

PROF WHITEFORD: That's good, thank you.

MS ABRAMSON: I had one question, Associate Professor, and that was really about how many people do see their GP and anecdotally I would have thought it was quite common for people to go to the GP and you've said to us there is another method, they could be

recommended the CBT and they aren't and we're very keen on GP education so I'm really interested in (indistinct words) what you say.

ASSOC PROF YOUNG: Yes, so insomnia is the commonest sleep presentation to GPs and I think it's in the top ten for reasons to present sleep-related problems to the GPs and that's date from the BEACH Report. The issue is GPs in medical training there's about two hours of training devoted to sleep cross the entire program so that's been surveyed in Australia and Asia Pacific as well and so the problem is that a GP's potentially not equipped, you know, to manage these because it's a complex problem. You know, someone may present with insomnia and depression and work stress so the issue is that as I mentioned only five per cent of the patients presenting to GPs who could be appropriate to receive cognitive behaviour therapy and some received that referral but it's skewed towards, you know, prescription of medication. About 90 per cent receives sedative medication. Now, that's data is about ten years old so it may have changed, it hasn't been reviewed again recently, so we would like to see a shift away from sedative medications towards CBT and referral to a sleep psychologist for management of insomnia in selected cases.

MS ABRAMSON: Do you think that part of that is about community expectations when people have insomnia they go to their doctor and they expect to be given, you know, medication for it?

ASSOC PROF YOUNG: You're right. I think it's multifactorial; there's community expectations, there's short consult times for GPs which, you know, it's quick, it's fast to prescribe a medication than do a full sleep history and social history and so on, psychosocial assessment, so I think there's multiple factors but I think, yes, educating GPs is one, educating the public is another and those are those two recommendations. Insomnia is a huge part of our, you know, obstruct sleep apnoea insomnia are two (indistinct) that we want to educate the public and primary health practitioners to improve but it will have flow on effects to mental health I think if we can implement those programs.

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

ASSOC PROF YOUNG: Great, okay. Thanks very much for the time.

PROF KING: Thank you.

PROF WHITEFORD: Thank you.

PROF KING: And next we have Louise Glanville from Victorian Legal Aid.

MS GLANVILLE: Good morning.

PROF KING: And if you could just state your name and your organisation and if you have any opening comments for the transcript.

MS GLANVILLE: Thank you very much. My name is Louise Glanville and I'm the chief executive officer of Victoria Legal Aid. Victoria Legal Aid employs about 900 staff, the majority of whom are lawyers and we act essentially for people who are very disadvantaged

and very vulnerable in terms of defence lawyering particularly in the indictable and summary crime spaces. In the civil spaces we are very involved with disability-related issues, mental health-related issues, issues to do with immigration, issues to do with income security.

In the family and children's law area we work clearly with federal legislation in relation to family law generally in relation to child protection, that covers probably most of our primary areas at Legal Aid. Importantly over the last probably five to six years we have really grown our practices that relate to mental health, we have a mental health legal team as well as a non-legal advocacy team called IMHA that you might be familiar with which I think you are from your interim report and I can speak to this further but this talks to the importance for us of having both legal representation and non-legal information for people when they're dealing particularly with mental health issues.

We see each year about 100,000 unique clients. 'Unique' means that there are many of those that would contact us more than once but generally 100,000 is the figure that we would use and of those about a quarter would identify as having some sort of mental health issue. We believe this is an underestimate of the reality of the situation but certainly one of the critical issues for us is that we see the intersection between a range of issues that we deal with, whether they're in the civil space to do with those that I've mentioned or indeed housing or others or in the criminal space, summary and indictable crime in relation to people also experiencing mental health issues.

We're very pleased to see that the Commission's adopting a system wide approach to this issue. I think it's particularly complicated but I think one needs to consider my within a systems context and understand the way in which a range of issues intersect and impact on someone's mental health so psychosocial issues, housing issues, employment issues, support issues and in that way we very much commend the Commissioner for essentially that approach. We believe that essentially, and I'm speaking primarily from Victoria, of course there is also a Commission going on here in Victoria and we have provided advice to that Commission on what we are seeing on the ground but very clear that often people have to really be in crisis in order to get the assistance they need and so we are really advocating for a system which not only responds to crisis but more holistically deals with prevention and early intervention particularly in the community space and other spaces before people are picked up as a consequence of really falling off the end of that particular cliff.

As part of that we think housing remains a very significant investment for all governments to be thinking about. It is very disturbing to us when we see clients who can't perhaps go out in to the community after they've perhaps had a term of imprisonment or been in a hospital in a secure space because there are not the appropriate sort of options for them to be able to access to get the support and to enable them to be on a recovery journey and I suppose that is a primary orientation we have that we think the mental health legislation in every jurisdiction, and ours included here in Victoria, needs to focus more thoroughly on sort of the journey, the recovery process, as distinct from the crisis responses that currently we think primarily occurs. This is important also, because we really want to enable people to live healthy lives, and to make a contribution to the community.

And I think there are more Productivity Commission reports now in a whole range of areas; it could be - NDIS is one good example, and the work that the Commission did on that many

years ago now, which indicates that if we have the right systems and supports in place for people, they can become more included in life, they can contribute more fully, their carers can contribute more fully to their own lives, and all round, governments probably across Australia would continue spending the same money that they do on mental health systems, and mental health issues, when in fact, we could be really looking at the sorts of productivity that could help people contribute to life more fully when they're suffering from a mental health issue of some sort. So I think this is a particularly important point.

We also support that intersection with other systems, and I draw your attention to the income security system, which is also one that we come across many, many of our clients experiencing difficulty in that space who do have a mental illness. The robo-debt challenges that we're currently running is key part of what we've seen, where people are - experiences a system that is complex and confusing and requiring to people - people to pay money that in our view they don't actually owe, as we've now shown in several instances. So I think that focus is good as well.

And importantly for us, we try and practice at Victoria Legal Aid the importance of serious, proper, and early inclusion of people with mental illness in helping design the sorts of responses that we should have to the issues that they raise. It's terrific the Commission has picked up on this as well. I think we are well and truly in Australia in an era of youth centred design, and I think we need to understand what this means for well-developed systems, and how in fact those systems can better respond to the needs that people have.

Finally, I perhaps want to touch on what we would see as mental health issues and the connections with the criminal justice system. It is of deep concern that we do see people who come in contact with the criminal justice system because there has not been, in my view, appropriate supports for them on their journey, and perhaps their demise is a consequence of the mental health issues they're facing, and in this way, I think we have some very important work to do as part of this Commission, and indeed, the one in Victoria, in thinking about how we can properly support people so that their trajectory is not one of diminishing, but one of growth contribution and inclusion in communities.

And so I commend the Commission, and so does Legal Aid commend the Commission for the work that it's doing, and I would like to perhaps just end with a quote from one of our senior consumer consultants. So we engage people who themselves have lived experience of disability and mental health issues. We have advisory committees that support this, and this is a comment by Linda Bennetts, who said, and it's included in part of our materials, 'Now is the time for a total rethink and genuine cultural shift. We need more services, better services, and importantly, we also need alternative services.

'Let those of us most impacted by the system lead the way in designing a new system that works for us. We want services that are amazing, that you would consider good enough for yourself or your families or your friends.' And I find that particularly poignant, and I think there are many stories that are included in our submission in which we could provide to you, of course with the consent of the relevant owners of those stories, that attest to the ways in which your thinking that contribute to that actual vision. Thank you.

PROF KING: Thank you very much for that.

MS ABRAMSON: All right. Thank you. Thank you very much, Ms Glanville, and can I also, on the record, thank your staff for the help that they have provided the Inquiry.

MS GLANVILLE: Thank you. Most of them are here, I think.

MS ABRAMSON: Thank you. I'm going to give you the invitation to take up on your last point, because you will have noted in our report that we really - one of the difficulties for the Commission was, because it was part of a very broad report, and we were looking right across Australia.

MS GLANVILLE: Yes.

MS ABRAMSON: So we did see - we spoke very much about diversion and trying to prevent people coming into the criminal justice system. We spoke about what happens when you're in jail, and also on release. But I'm really interested in taking up your last point about, well, what can we do differently, and your views of some of the diversion programs.

MS GLANVILLE: Yes. So in Victoria, I think we have quite a proud history of therapeutic jurisprudence, or what I would call sort of more commonly, problem-solving courts. This isn't the person who's the problem, it's the things they're experiencing that are the problem. But I think this is a very important piece of any justice system in any jurisdiction.

So courts such as the - perhaps the Neighbourhood Justice Centre, or the Family Violence Courts, or the ARC List, which is the Assessment and Referral Court, look not just at perhaps the offending that the person has done; that's clearly why the person is there, but they also look at the needs that this person might have that might have contributed to the offending, and it is very clear that it is a slippery slope for some people when their social issues become overwhelming. They perhaps don't have housing. They perhaps have fines that they cannot pay. They perhaps sleep out quite a bit.

They perhaps get picked up for what we would call quite minor crimes, such as perhaps stealing a small amount of petrol from a petrol station for a bike, or whatever it might be. It's very easy to see how these people can become involved more thoroughly in the criminal justice system, and in this way, the broader causal factors, what I would call the social factors, of their lives don't get taken into account enough. And I think the worst thing for most governments is to have many, many people in prison, because we know that this is not only expensive, but often it doesn't produce very good outcomes for those that are there.

So the courts like the Assessment and Referral Court in Victoria, it looks holistically at the person. Where are they living? Do they have a mental health issue? Are they employed or not? Are they included in life in a sort of a real way? And this process happens; it's a diversion from the court. This process happens, and then it's still part of the court, but the matter then comes back before a magistrate or a judge, as the case may be, with much better information about what this person is experiencing.

And in that way, I think those sorts of diversions based on problem-solving approaches and therapeutic jurisprudence, as I would call it, have really shown to be very efficacious. I also

think that some of the approaches that Legal Aid has used in the civil space are very good in this respect. So we go to every - we're in every public hospital in the state, offering information through our IMHA service, Independent Mental Health Advocacy, for people that are either at risk of compulsory treatment, or who may be experiencing compulsory treatment.

And this is important, because often the lawyering bit of it doesn't need to be immediately upfront. So we believe that legal information, as distinct from legal advice or legal advocacy, has a real place in connection with legal services to talk through the sorts of things that people might be wanting to think about in this space, and it's through that work that we have also been able to think about ways of people not becoming so embedded in systems, but also to be looking at what's the path to recovery, rather than what's the path deeper into some of the very expensive systems that we have in Australia.

Necessary, always necessary, for those that are in crisis, but shouldn't be the primary route that people are following when they do begin to get into that sort of more serious difficulty.

MS ABRAMSON: Thank you. Two things about that. We had heard, and of course we've spoken Australia-wide, that one of the issues with the court diversion programs is they're not available in all areas.

MS GLANVILLE: Yes.

MS ABRAMSON: And interested in your comments on that. And the other issue is a broader issue which goes to our report. We're very interested in linking people up with services, so I wondered what your experience was with the diversion programs with people being able to get the mental health support services or psychosocial support services that they needs.

MS GLANVILLE: Yes. So the way in which, certainly in Victoria, but I think probably in most parts of Australia, problem-solving courts or therapeutic jurisprudence has been developed is usually by pilots, and things have been tested. And often when those things work, then they're rolled out, but not always. So we like the model where, where does evidence that says something's working and it's good for individuals - - -

MS ABRAMSON: We like the evidence too.

MS GLANVILLE: I know that, from having read many of your reports, which I find incredibly helpful over time, as well as in the instant. But I think often what happens is that governments may or may not have the resources to actually do that rollout, and it also requires, I think, a cultural shift in the way our justice system works. I think diversion per se, perhaps if you look at police and police responses, often the police response will be to not divert, just because they're focused on perhaps the crime, and the focus is on bringing people to a court.

And so there's lots of parts of the system, including the courts, that need to culturally think about diversion and the way in which that can assist. So I think, when you look at the evaluations of some therapeutic jurisprudence initiatives, ARC is one good example here, as

I said, but the Neighbourhood Justice Centre as well. I think the last time I looked at its most recent evaluation, its breach rate; that is, where people breach the orders they're put on, was 15 per cent less than in any other Magistrates' Court in Victoria.

Now, I'll get back some confirmation of that, and we'll perhaps send that to you. But I'm pretty sure that figure is still about right. And so in and of itself, you would think that it is useful to be able to roll those sort of things out more thoroughly, where in fact they are proving to be beneficial. In terms of service linking, that is one of the roles that IMHA plays for us, the Independent Mental Health Advocacy, which is why I really like it, because I think it moves it away from just what are your legal rights, which of course is fundamental to us and very important in terms of the Mental Health Act in the compulsory treatment context.

But it also looks to what could assist people in terms of being on that journey back to recovery and being able to be included and living a fuller life. I think it is very well known, not only from the evidence to the Victorian Royal Commission, that there are a lot of gaps in the service space, and in fact, we struggle at Legal Aid to really see a system as such, a mental health system, and that's not unique to Victoria. It's just the, I think, the complexity, the growth, the greater understanding in what we understand mental health issues, how they affect people.

And it's also sort of relevant even to our workforces, and the issues that arise perhaps from, if I think more generally, the perhaps lack of attention to bullying in workplaces, or sexual harassment; all these things can lead to certain outcomes for people if they're not dealt with in an appropriate way. And so I think the sort of service linking part is a continuous project for all of us, but I think we need the road map. You know, I think we need to know, what does the endpoint sort of look like, in order to get there, and - so that we can work towards it.

And clearly, the endpoint should be on diversion. It should be on assisting people to be well supported in community, even at the early intervention stage. It should rely on tertiary services like hospitals and prisons, and as a last resort, in my view, and clearly people who need services at crisis point should get them, but we should have a much longer sort of process in terms of people getting to that point, and people being picked up earlier, rather than having to be very, very unwell in order to get any sort of service at all, and clearly, accommodation is a very key part of that. Appropriate housing, as is income security, in some way.

MS ABRAMSON: Thank you. Having asked you all the questions, I'll let my colleagues - - -

PROF WHITEFORD: So just one question. Do you have interface with community treatment orders in Victoria?

MS GLANVILLE: Yes.

PROF WHITEFORD: And how do you think they work for client?

MS GLANVILLE: That is a very good question. I would have to take some advice myself from the people that deal with that to understand that. But my sense is that, in some instances

they're needed, and in some instances they may not be. I think the way I would answer that, from my sort of more systemic, broader knowledge, would be that sometimes we get to that point without having considered other things that might be possible, because of perhaps the lack of linkages to other things.

Because of the, what I would call sort of psychosocial social issues as well that impact on people and perhaps mean they can't function as well. So I'm sure, and I'm not a psychiatrist, and I don't pretend to be, and Legal Aid - I don't think we have any psychiatrists in there, from knowledge, but I'll probably be proven wrong by someone when I go back to work. But our job is to sort of support people with their legal and non-legal issues, and in this way, I think the reality would probably be that for some people, compulsory treatment orders are something that would be useful, and for some they're not.

I think it's probably quite a contested space. One thing we do think is very important that I think we have raised in our submission with you, or if we haven't, we will more thoroughly - we will give you those details - is the importance of consent in these processes, and even with compulsory treatment to be considering what the person themselves would say about whether this is in their best interests, or whether this is something that they feel would be useful, moving away from the best interests terms.

So really engaging with the person themselves. A matter we ran in the Supreme Court which, I think it was last year, found that too often matters had become - were being presented as emergencies and urgent, and so therefore the appropriate engagement of people - of the people who are the subject of a compulsory treatment order was not in place necessarily. And there was not enough consideration of their wishes.

I think sometimes there's a view that if someone's in this state, they can't have a view. Well, of course they can have a view. You have to test these things out, and so we would advocate that's a very important part of putting the user or the person at the centre of the experience, to actually engage with them, and that's why the IMHA service and our legal mental health team aren't very critical in that space as well.

PROF WHITEFORD: Okay. Thank you.

PROF KING: Just one thing, and just maybe covering areas where our team has already got information, but from memory I don't think we have, and that is the different outcomes before - from mental health tribunals, depending on whether there's legal representation or not.

MS GLANVILLE: Yes.

PROF KING: So we've heard - - -

MS ABRAMSON: It's in the report.

PROF KING: Yes, we've heard anecdotal evidence that there is a different outcome. I'm not sure if we've got the statistics, or anyone's actually put that to you.

MS GLANVILLE: So we can provide you with that material. So I think in Victoria, from memory, it's about 15 per cent of people are represented at the mental - in terms of compulsory treatment, and in other jurisdictions, it's quite different. So there's a lot of - that's a hard thing about the Productivity Commission; you're across Australia, and so we really want the best from all around Australia to be captured by your report, the best practice.

And I think what we'll do is we'll send you some material on that. We certainly have done quite a bit of work on that, and that will probably be the most useful.

PROF KING: Sorry, it's more than just the representations, actually. If there's evidence of differing outcomes, systematically different outcomes, but any other legal representation.

MS GLANVILLE: Right.

PROF KING: Sorry, I didn't make myself quite clear.

MS GLANVILLE: I think there probably is, from what I can remember, but I will take that - - -

PROF KING: Fantastic.

MS GLANVILLE: In fact, I'm sure there is. I will take that on notice. Thank you.

PROF KING: Thank you.

MS ABRAMSON: One other thing that I did want to ask you about is when people leave prison. So, one of the things that we observed in our report was there's a lot of churn that people are in for what the system would term as low local offences. So they're sort of there for 12 months to 18 months. And then your observations, if you're able to make them, of the ability to link them with services, particularly if they're not on parole.

So they're released into the community, but under parole, they're will be some supervision, but without parole, how they're - you know, what the situation is with access to services, hence the likelihood that they come into contact again with the criminal justice system.

MS GLANVILLE: I think the widely held view would be that, particularly in relation to housing and supported housing options, and there are - you have a number of people this afternoon who you've asked to give evidence who will be able to speak much more eloquently than I can on this, but as someone who's always had an interest in housing, because it is so fundamental to people's wellbeing and ability to be included in life, that is a very fundamental aspect of where people stay and live post any prison period.

And we do know that sometimes, very, very sadly, people are in prison because there is no other place for them to be, and we've had several matters in relation to the NDIS where this has been the case. So it really requires governments and communities generally to be thinking of how do we have the stepped up and stepped down options that are going to support people. And of course, housing, I think, is the most basic thing, to be honest with

you. I think if you've got somewhere to stay, that's a big plus in filling a level of stability in your life, and then surrounding that should be the other services that people need.

But I would say housing is probably one of the most critical, in terms of people's journey back into being able to contribute more thoroughly to the community and the society that they live in.

MS ABRAMSON: Thank you. Can I ask one final question, if I may, and I happen to be a lawyer, which is why (indistinct).

MS GLANVILLE: Good.

MS ABRAMSON: If that was not obvious before. Just the civil side of your work. Like we focused on the criminal side in our conversation this morning, but the evidence that we found was that people with mental ill-health were likely to have more issues in the civil side. You touched on housing, so your work in that area would be interesting to us.

MS GLANVILLE: Yes, and that's very much the case. I suppose I'd say housing, but fines as well.

MS ABRAMSON: Which you touched on (indistinct).

MS GLANVILLE: Yes. The NDIS. We have quite a large practice now in relation to supporting people as they go through that process. I should say, Victoria Legal Aid is a very big supporter of the National Disability Insurance Scheme. We want it to be as good as it can be. We see many - well, we don't see the many fantastic examples of it, but I know they are out there. What we see is, often when people are in strife and difficulty with it, but that is a critical area.

Immigration matters; we see issues that relate mental health issues, and I suppose really too in sort of the employment law, and particularly the discrimination space as well. I think this is a very important area to look, and goes to the points you've made in your report about needing that more systems wide lens to thinking about productivity issues in relation to people with mental health issues in all the intersections they have with different systems. So, if you were interested in that, we could make a little summary for you, of what we're perhaps seeing in each of those areas.

MS ABRAMSON: That would be very useful.

MS GLANVILLE: Some of might be qualitative, some of might be - some will be quantitative, some will be qualitative, but to give you a bit of a flavour of that, and we are well placed to do that, because we are in every Magistrates' Court. We're down at VCAT. We're in public hospitals. We'd like to probably be in private hospitals as well, but not funded for that. And it will give you a sense at both the commonwealth and the state level the sorts of matters that we see where there's a real intersection with people's mental health experiences and their mental health issues.

MS ABRAMSON: Thank you.

PROF KING: Okay, thank you. Thank you.

MS GLANVILLE: Thank you very much.

PROF KING: Thank you so much. Perhaps if we just take now a break for morning tea. Perhaps about 20 minutes. Let's start again just a little bit before a quarter to.

SHORT ADJOURNMENT

PROF KING: Let's recommence the hearing, and there is something - - -

MS ABRAMSON: Are you right, Stephen?

PROF KING: Yes. I'm just seeing if there's anything else that I need to mention. Just for those of you who have joined us since this morning, just a couple of things. Obviously, phones on silent. The microphones are for the transcript. They're not for amplification, so I hope you're able to hear. It is being live streamed on YouTube, so please be aware of that, and if you - if any of the participants do not wish to be visible or audible online, then you need to make that clear to our team members as soon as possible.

If there are members of the press here, please let our team members know. And that will probably do it before we recommence. So, the first present, or first participant after morning tea; Robyn Hunter, please. And if you could name, affiliation, for the transcript, and any opening comments you'd like to make.

MS HUNTER: Thank you. My name is Robyn Hunter. I'm the Chief Executive Officer of Mind Australia. Mind Australia is one of the country's leading community managed specialised mental health service providers. We have been supporting people dealing with the day-to-day impacts of severe and enduring mental illness, as well as their families, friends and carers, for over 40 years.

Our 900 staff deliver services in our own centres, and outreach programs, and residential services, and in step up and step down services in partnership with clinical agencies around Australia. In the last financial year, Mind provided over 400,000 hours of recovery focused, person-centred support services to over 9,000 people, including residential rehabilitation, personalised support, youth services, family and carer services, care coordination, and step up/step down services.

Mind welcomes the Productivity Commission's inquiry and believes it is a major opportunity to re-evaluate Australia's mental health policy and service system beyond the historical framing of illness and medical interventions. We welcome the draft report from the Productivity Commission, and as we read through, analyse and consult with our staff on the 1,238 pages of the report, our initial thoughts are that it's heading in the right direction, and offers welcome reforms to improve the mental health system.

We offer these further insights at this hearing across three areas. Workforce, housing, and carer inclusion, to ensure the final recommendations remedy inequities in social and economic determinants in equal measure to those that deal with the treatment and management of the symptoms of mental illness. We will also be lodging a follow-up submission by 23 January, which will expand upon these points in greater detail.

Community mental health workforce. We welcome the recommendation to strengthen the consumer and carer peer workforce, and see this as a positive step forward in the provision of recovery oriented mental health care. However, we see a significant gap in the report in relation to the community mental health workforce. The community mental health workforce, which makes up the bulk of Mind's 900 staff, are facing significant challenges, and we, as an employer, are experiencing an uphill battle to attract and retain our staff. This must be central to the development of a new workforce strategy.

We understand from some of your Friday hearings with Mental Health Australia and Mental Health Carers Australia that the Commissioners are having difficulty in understanding the demarcation between acute, sub-acute, and psychosocial, and that competing language is confusing. Psychosocial community mental health supports give greater emphasis to addressing social determinants and rehabilitation needs. There are specific roles for consumer and carer peer workers.

We seem to be fighting for community mental health professionals who are skilled in recovery oriented practice and support to provide family focused and care inclusive care, to be considered as a critical component for complex care, high-intensity care, and moderate-intensity care. Our staff are facing great uncertainty. The current configuration of commissioning models, short-term contracts, and delays in contracting and short notice periods for contracting end dates, is combining to create uncertainty for workers, and this is evident in rising sick leave, turnover rates, and difficulties attracting, recruiting, and retaining staff.

These issues have been further exacerbated by the NDIS. Our experience indicates that the low price point for psychosocial community mental health signals this workforce is undervalued. In the regulated pricing regime of the NDIS, our experience of the transactional nature of funding, the low pricing of supports, and no allowance for provider travel, has provided a significant challenge to the provision of outreach recovery oriented practice.

With retention, Mind has bucked the tide towards a casualised workforce, and has demonstrated this commitment to our prized, dedicated, and experienced workforce by providing ongoing employment contracts. This is to retain our workforce. Their pay is grandfathered at a higher price point to reflect their qualifications, years of experience under (indistinct) and practice wisdom. This costing millions from Mind's financial reserves. We would like to work with the Productivity Commission further to develop a community mental health workforce strategy that addresses our concerns.

What is working is a team-based approach, including consumer and carer peer workers, community mental health practitioners with recovery oriented practice supervision and training. Further, in Queensland we are investing in upskilling our workforce in complexity

to reflect the increasing acuity and complexity our clients are presenting to us, to support them on their recovery journey to live contributing lives.

Housing. We contended quite clearly in our submission that supported housing needs to be viewed as a health response. It is pleasing the Commissioners have recognised this with recommendations that acknowledge that suitable housing is a first step in promoting long-term recovery for people experiencing mental illness. We welcome focus on improving SDA, Specialist Disability Accommodation, for people with psychosocial disability, especially in regard to lifting restrictions on the number of people who can reside in SDA.

We would ask the PC to further investigate the SDA funding eligibility for people with primary psychosocial disability, and the lack of investment in SDA for people with psychosocial disability. As we mentioned in our submission, Mind is partnering with AHURI to develop a clearer understanding of the relationships between housing and mental health pathways of people with mental health issues, in order to identify potential points of practical intervention and key issues for system improvement. This research will be published in February 2020, and we would be very happy to share this with the Productivity Commission.

Carers. Mind is of the firm belief that carers and family involvement need to be embedded through the mental health system, and their role strongly supported in the workplace. We welcome the Commission's chapter on carer and families, and the recommendations to improve the carer payment and carer allowance, especially in relation to the 25 hour rule, but hope the inclusion of this cohort can be expanded in the final report to be embedded across the whole mental health system.

Mind and other organisations developed the Practical Guide for Working With Carers and People with a Mental Illness, and we think the PC should consider ways to mandate the six partnership standards contained in this guide. The guide partnership standards were developed through co-design, integrates consumer and carer outcomes, providing a tried and tested approach.

Carer inclusive workplace practices also need greater consideration. There is scope for government departments, unions, and the National Mental Health Commission to partner on developing a framework for carer inclusive workplace practices. We look forward to contributing to specific points raised in the draft report in our final submission.

And finally, the social and emotional model of mental health. The final report must provide a greater focus on the social and emotional model of mental health which strongly considers that social and economic determinants, and the relational aspects of mental health, are crucial to recovery. A social and emotional model of mental health would place a person at the centre of their supports with a greater focus on the wellbeing of their most important interpersonal, day-to-day relationships.

While this has received attention in the draft report, we still think that it has too much of a focus on the medical model of mental health, and we require a clear vision for what we want our mental health system to look like in the future. For Mind, this is a recovery oriented

model that clearly places the treatment or management of symptoms of mental illness alongside interventions that deal with the impacts of those systems on people's lives.

PROF KING: Thank you. Just a couple of clarifying things before I pass over to my colleagues. Yes, we love the joint work you're doing with AHURI. When that's available, we'd be very grateful if that could be sent in. Two clarifying things. Firstly, when discussing the carer allowance, you said you'd like to see some - I'm going to paraphrase; my apologies. Something like, 'this embedded over the whole mental health system.' Were you talking about things like carer inclusive workplace practices, or? Okay. So I now understand. So the comments that were following on was - were referring to that; that's fine.

And just the last one, because this is again something that's troubled me a number of times. At the end, you mentioned the social and emotional model of mental health versus the medical model.

MS HUNTER: Yes.

PROF KING: And I guess, as a non-clinician, and someone who comes from outside the sector, I do find that juxtaposition slightly odd, in that what we tried to do, and perhaps we could have communicated it better in our draft report, but what we tried to do is make it very clear that, well, you can't have one without the other. That you can't have success in the medical model unless you've got things like appropriate housing and supports and community.

But nor can you say, well, let's ignore the medical side of this and just have appropriate supports and community without having the clinical side and clinical support. And we know the issues that arise when people don't seek appropriate clinical support. So could I just get you to expand? Are you saying that it's one or the other?

MS HUNTER: Definitely not.

PROF KING: Or are we wrong in what we've tried to do?

MS HUNTER: No, no. I think it's reflecting a desire for a greater balance. So I think that it's - Mind does a lot of very important partnership work with clinical agencies in the sub-acute or step up/step down space, and I think that's a lovely example of where you actually have roles to play, and they need to be stitched together in a partnership so that you can actually really work on all elements.

I know there's some confusion in the language between community mental health and that that's provided by health services, versus that outside of that. And my simple explanation of that is, in the medical model, it's around managing and containing the symptoms of mental health, whereas the work that we do in the psychosocial space is actually trying to move towards rehabilitation, against particularly goals that are taking into account their social and emotional wellbeing.

PROF KING: Again, sorry, I'll pass you to my colleagues in a second. But again, is that really - is that saying - - -

MS HUNTER: It's not one without the other.

PROF KING: Hopefully a clinical system is focused on rehabilitation and recovery. So is it saying that there are different roles because of the different organisations, or is it saying, well really, we need to get more of a recovery focus into the clinical services? I guess, perhaps naively, I'm less worried about if it's sub-acute that's provided through hospital funding, or is it community-based services. What I care about is, are we getting the outcomes that the consumers want and require. So again, I have some trouble with this differentiation that, as an outsider, seems artificial.

MS HUNTER: My attempt to explain this is that people are presenting into the acute health system much more complex and acutely unwell than ever before, and they're being discharged from the acute system at a higher level of acuity than they were previously. So I really think that that's what hindering, from my acute colleagues, their ability to adopt this sort of practice. There are, you know, really quite severe pressures at the acute end for them to be able to adopt that approach.

PROF KING: But it's more the pressures in the system, and perhaps the incentives or the constraints within both clinical and the community provision of mental health services, rather than different objectives, as such.

MS HUNTER: Yes. Look, I think, again, coming back to your point; they're not one against the other. They're trying to do different, very important objectives, and they need to be done in a linked up way, a joined up way.

MS ABRAMSON: Ms Hunter, I just want to follow up a bit on what Stephen's been talking about, and come to a direct point. The way that the report is crafted, it's got the separate sections. We've got one that deals with the medical system, psychosocial supports. Bearing in mind what you've said, what type of recommendations, or the way in which we frame our conversation, were you interested in seeing us develop?

MS HUNTER: I think it's really to try and reflect for the community mental health workforce an appreciation of the specialism in the practice wisdom that they have through working with people. I think one of the greatest concerns we have is that the - I referred to it in the NDIS, but it is happening elsewhere - that the price point for the workforce is actually quite low, and it's not reflecting the training and supervision that is required to support people, particularly as people are coming through and presenting to our services more complex and more unwell than previously.

MS ABRAMSON: I mean, we have said - and I understand what you're saying - we have said that, as we also do, that the contract periods are too short, and I have to say, this is a consistent refrain of the Productivity Commission. But in terms of the workforce itself, those are, of course, broader issues about value for work and the nature of work. So have you got specific recommendations that you're asking of us in that space?

MS HUNTER: Look, I'll take that on notice - - -

MS ABRAMSON: Absolutely.

MS HUNTER: - - - and make sure that we do come back with some. I think one of the things that Mind is doing is really promoting undergraduate student placements, and really that's where people come in and develop a spark of interest and then, hopefully, a career commitment to working in the space. And so that's one of the things that I think was brought up earlier as well, so that it is seen to be a really fulfilling career opportunity, and that there is opportunities for career progression is also important. It's often around the job insecurity, as opposed to the actual wage.

But as an organisation, we're just finding that the - the specialism, and I'm trying to be careful in my terminology there, is well recognised and appreciated and valued for the work that is being done.

MS ABRAMSON: I might ask that, perhaps in your submission, you could turn your mind to that, and also, we've talked a bit this morning about stigma, so if you also had some ideas in that space, they would be very welcome. Thank you.

MS HUNTER: Okay. Thank you.

PROF WHITEFORD: So, just going back to the workforce issue. So the community mental health workforce that you're referring to, can you just give some idea of the - I know you've already touched on this several times, the types of people who would be - would make up that workforce? The backgrounds?

MS HUNTER: Yes, and I will put more specific data through. We haven't actually captured that routinely beforehand. What we have found in our experience of the NDIS is that our community mental health professional workforce, many of them have undergraduate qualifications in psychology, social work, OT, youth workers, and that through that - and I think this is an unintended consequence of the NDIS - but because the price point for allied health professionals is higher, by encouraging our workforce to actually become APRA registered, we can actually bill at a higher rate.

And I think that's regrettable. I don't think that we should be having those sorts of unintended incentives. The workforce is one that - for example, I'm thinking of a couple of team members who came through as students, and we've been fortunate to employ them as new grads and they're working in our supported independent living services as part of their career trajectory. Who knows where they'll up with their careers, but it really is making sure that they actually get an understanding of the different ways of supporting people with severe and enduring mental ill-health in their recovery process.

PROF WHITEFORD: Sorry, can I ask a follow up question then? So, if they're employed in one of your services and they have a psychology degree, or a social work or occupational therapy degree, are their pay points different to if they were working in a clinical service?

MS HUNTER: So, when they're employed by us, they're employed as community mental health practitioners, so they're employed under the SCHADS awards. If they were employed in a clinical mental health service, more likely they would be employed as a OT or a psych.

PROF WHITEFORD: And that means?

MS HUNTER: Different pay.

PROF WHITEFORD: And does that mean that you're likely to lose them to the clinical services?

MS HUNTER: Yes, we don't have a lot of - we haven't experienced that, to my knowledge.

PROF WHITEFORD: Okay.

MS ABRAMSON: Can I ask you, on an entirely different track, we've had a number of people comment that they would like to see more done in the CALD space. So I'm really interested, and we've got some information requests in our report, because we'd really like to know, what would that look like? What are the type of communities that we should be looking at, because there is so many multicultural groups in Australia. So thoughts on that, even in your submission, would be very welcome.

MS HUNTER: Yes, I'll take that on notice, but definitely come back to you.

PROF KING: Okay. The only other one from me was, you also mentioned peer workers and the peer workforce. We've got a number of recommendations in there, but as you mentioned a workforce strategy, we'd be very keen to understand if you think the sort of recommendations we've got have gone far enough, or if there's other things we need to recommend about getting peer workers. So right through the whole mental health system. We'd be very interested in hearing of that.

MS HUNTER: Certainly.

PROF KING: And, of course, ways to do it.

MS HUNTER: Yes. Will do.

MS ABRAMSON: Thank you.

PROF KING: Thank you.

MS HUNTER: Thank you.

PROF WHITEFORD: Thank you.

PROF KING: Next, we have Dr Peter Kent.

DR KENT: Commissioners, I do have some sketches and diagrams that might help understand what I'm talking about.

MS ABRAMSON: Thank you.

DR KENT: I'll just leave those here, if I might.

PROF KING: Thank you. And if you could state your name and affiliation for the record, and then any opening comments that you'd like to make.

DR KENT: Thank you. Well, my name is Peter Kent. My affiliation is I'm the founder of a new charity, and it's the process of being established, called Restart Health Services, and that is oriented to the needs of people with severe mental illness and comorbid, overweight and obesity as its core objective. I'm going to talk a little at the personal level, because there's a member of my family that's had psychosis and schizophrenia, and then more at the policy level. So perhaps if I start at the personal level.

My youngest son, who's now 31, and he knows I'm talking here, I've cleared that with him. Twelve years ago, in 2007, he was flying along in first-year university. He had been captain of sports at school, a healthy, fit young man. In his first semester, he was averaging distinctions in his grades in a combined Commerce/Engineering course, and then in the second semester, he fell into a first episode psychosis, and subsequently was diagnosed with schizophrenia.

So for the last 12 years, his mother and I have been his carers, and I have mostly involved in that world simply as a parent with a son who has a severe mental illness, and dealing with psychiatrists, and the normal things you do along the way. One of the things that's happened is that his physical weight has ballooned out. You'd be aware, of course, that the antipsychotic medication has clearly increased the appetite, and that's one of the factors in that.

He was about 72 kilograms when he fell into psychosis. A fit, slim, young man. Now he's about 105 or 106. So his weight's gone up 50 per cent in 12 years, and that creeps up on you. I mean, it's three kilograms a year. We didn't notice if for a while. When it got to 90, hey, you're getting a bit heavy. Do you think you cut it back? And we have managed to stop or, or stop it increasing at around about his current level of 105 kilos, and I'll explain why in a minute.

But what we found he was doing, is that we could sit down and have an evening meal together, and then an hour later he'd say, I'm hungry, I'm going out. And he's off to one of the fast food chains and buys food, and sometimes not just the food, but a family pack. I mean, the hunger is really driving. He wants to bring his weight down. He's trying to do that; he struggles. We've said to him - we've tried multiple things, of course - but we've said, look, if you're going to get a burger, don't get the fries and don't get the soft drinks. And he's probably compliant about 70 or 80 per cent with that.

And he therefore has plateaued off his weight, but he still finds it very hard to bring it down. We are aware, indeed acutely aware, that the - there's foreshortening of life for such people, as you would know, that - usually by 10 to 20 years is the common sort of range, and they're subject to early death, mostly from the physical comorbidities, which generate the cardiovascular problems, the Type 2 diabetes and so on.

So that's in the back of my mind here, and when I heard about your Commission earlier this year, I began to shift gears and think, well, let's not just look at this at a personal level. What about the national policy level? So I'm going to talk a little bit about that too, and where I've come from. I'm going to talk about the needs and delve into the problems a little bit, but I also think there's some potential solutions that aren't invoked yet here in Australia, which can help these people, and indeed have a small impact on suicide reduction. So I'll to that in a few minutes.

So I'm focusing on the people with severe mental illness, and by that, I mean schizophrenia, schizoaffective disorder, bipolar and severe depression as the core group, and the comorbid, overweight and obesity. And if you want to have a look at that first diagram, it's just - - -

PROF KING: Because of the way the hearings are done, Dr Kent, we may need to deal with this as a submission, rather than running through it here, because of course, the transcript can't see diagrams.

DR KENT: No.

PROF KING: So rather than spending time on this - I understand that you may want to draw our attention to some diagrams, but please do it in a very minimal way.

DR KENT: Okay.

PROF KING: Because otherwise, we obviously lose, not just the transcript, but also 100 or so people who are viewing this online.

DR KENT: Yes, okay. All right. I shall do that. All right. What I want to do is to mention the problem to start with, and then that's to show the severity of it, and then move on to what we can do about it.

MS ABRAMSON: But Dr Kent, did you want us to take this material as a formal submission to the Inquiry?

DR KENT: Sorry, I beg your pardon?

MS ABRAMSON: Do you want this to be a formal submission to the Inquiry?

DR KENT: Yes, I think, so. Thank you.

MS ABRAMSON: Yes, thank you.

PROF KING: Sorry, I hadn't assumed that. My apologies. Yes.

DR KENT: Yes. So starting with Australia's obesity, we have - the Australian Bureau of Stats shows that it's going up and up and up. We now have two-thirds of the population, or 67 per cent as of 17/18, who are either overweight or obese, and that is about roughly half overweight, and roughly half obese, and that's going up. So that's a background fact that affects all of these people with mental illness.

And of course, those who have mental illness and are being treated for it, have - as I noted in your report, there's other factors apart from the background factors. There's the medication. There's the low income, which gives a propensity to buying cheap foods. There's a lack of exercise, there's a lack of nutritional knowledge, there's a lack of cooking skills, and so on, all in the mix contributing to this total problem. So it's well known that, as I have touched on before, that we have these problems of early death resulting from this.

When we look at this in a relationship context, overweight tends to drive obesity, and there's quite a lot in the literature says there's a relation - a two-way relationship between obesity and depression, or mood disorders. So if people are overweight, their self-image goes down, and other things go down, so they tend to become depressed. And the other way people are depressed, so they don't exercise, they get junk food and they become overweight. So you've got that two-way relationship there.

And with these people with mood disorders, or with depression in particular, the ABS stats shows that we have about 44 per cent of them, when they analyse the causes of suicide, the biggest single cause is depression, in about - it's your report too; 44 per cent or so there. So links between food, eating practices, obesity, mood, and suicide. There's a correlation all the way through there.

MS ABRAMSON: Dr Kent, I apologise for interrupting you, but I'm particularly interested in your solutions and the recommendations that you make. Is there anything in the material that you're presenting to us now about the statistics where you feel that perhaps the Commission has not understood the extent of the problem?

DR KENT: Yes, I think there is one bit, which I'll come to in a minute. Can I draw your attention to just one thing here, and that's some very good work out of Melbourne here, with the Food and Mood Centre, led by Felice Jacka, on changing the diet of people who had poor diet resulted in a drop in depression by about 30 per cent. It was a big factor there, and that's been verified overseas with other studies. So this is the beginning of this nutritional psychiatry field where changing diets is starting to impact on outcomes.

Now, this is the bit that I think perhaps you haven't got in your report. On your website, you've made the claim that suicides, or years of potential life lost and suicides outweigh those of road accidents, and you've got the things to show that. Just when I take that a little bit further and look at the population with severe mental illness, and this - your figure is 775,000, broken up between episodic and complex and so on, but nearly 800,000. And we can say that, conservatively, 75 per cent of those are overweight or obese, because we're building on a population base of 67 per cent.

When we break that out, it means we've got nearly 600,000 people who both have severe mental illness and overweight or obesity. And when you look at the years of life lost, potential life lost from that group across the entire population, it multiplies out to about 8.7 million years of potential life lost. So that's over that population. So if we assume that the population, say mental illness onsets at the age of 20, and they live to about 67, because that's the average age they will live to, that's a population age range of 47 years. So, in essence, that population changes once every 47 years.

And if we divide through - the figures are in that report there - it means that, on a yearly basis, the years of potential life lost from severe mental illness and comorbid, overweight obesity are about 185,000 years of life lost per year, and that is more than the combination of suicides and road accidents combined. And the reason I'm mentioning that is just to mention this and put it into context, just how significant it actually is for these people.

So when we come to address this problem; what can we do about it, your report says, I think, on p.6, 'There's substantial underinvestment in early prevention.', and I would agree with that. I think there's also substantial underinvestment in facilities and services for these people with severe mental illness, and part of that may be that it's just been in the too hard basket. What can we do about it? If we do spend money, what are we going to do?

I want to talk about the introduction in Australia of residential therapeutic farms, right, that to date don't exist here. There are a couple of farms for drug and alcohol rehab, and so on, but they don't really exist here, and I was looking through this possibility, because when I go back to my son, and you want to help him to reduce his weight, when you're here, you can go down and buy fast food anywhere.

If we take people like this who may be either at home or in non-acute beds, depending on where they are on the spectrum of illness, if they're in a farm, they can't duck down the street and buy cigarettes. They can't duck down the street and buy burgers. The only source of food is the farm dining room. So you have some range of control over people's diets. So there are farms of this type in America, and I've just been on a study tour last month of four of these farms, and they've been very, very helpful. They have evolved over decades, and they have a lot of accumulative experience.

They're doing all the things that we do in some of our post-acute services around Melbourne, around Australia, but they're doing it in a natural environment. And immediately, once someone moves to the farm, they're in a relaxed, rural space, rather than in a high-pressure urban space. They are able to interact with animals. Some of them use animal therapy, so dealing the donkeys and the horses and so on. Some people, some of the residents, relate to these animals before they can relate to people. There's lots of ways to set up therapeutic processes there.

I've given reference here to the four farms that I visited. You can look at their websites, and there's far more in there than I can possibly cover this morning, so I'll jump over that. But they're all excellent places. But a well-structured therapeutic farm offers the full range of clinical services, psychosocial services, community-based services, in a safe, supportive environment. Now, if we're going to set this up in Australia, the first thing you start with is safety.

Now, when people come into these farms, they might have been just discharged from an acute hospital, or they might have avoided the acute hospital and gone straight to the farm, because they're at that level of severity. And people who are unstable in this way, they watch them very closely. Usually on these farms, they have group housing dotted around, which might be eight or 10 people in a group house, with a resident adviser in every place. But the ones who come in initially, for the first 30 days or so, they're in a house, if you like, attached

to the administrative area, and they are watched, unobtrusively, but there's observation of these people every 15 minutes. So it's 24/7 coverage. Even during the night, there's someone popping their head into their bedroom to see they're okay. It's all designed - there's no hanging points, and so on.

But they are well of the possibility of suicide with this population, and I think your report or other says that the risk is about 100 times higher than the normal population with this group. So you really do have to watch them very closely. Once their stabilised, it drops down to about every hour, you know, where somebody is - so there's a lot of resources there. One of the things they do on the farms is to say, during the induction period, well what are your wellness goals? And they might be reduction of clinical symptoms, improved self-esteem, improved social skills, improved diet and cooking skills, and a lot of them asking for that; an understanding of nutrition.

Increased personal organisation and life skills, loss of weight for those who need it, becoming a non-smoker for those that want to go down that track, improved overall health, and improved readiness for work. They're the sort of objectives that people tie into here. So they're wellness goals. The sort of activities that they engage in day-to-day, there's a much wider range of options than there is in any city-based activity.

One of the farms, I stayed there for a week, and I got involved in the grassroots work programs day-to-day, and they have team leaders in each area, and the team leaders might be someone who's a farm man who's trained in agricultural matters, but they also have to be selected for their quality of personal empathy, and some degree of training in the psychological or psychiatric issues. And there's a two-way flow of information all the time.

At the top of the clinical pyramid is the psychiatrist, and then there's social workers and psychologists in that mix, and information flows down and it may be that the farm guy's told, look, Harry's been unstable, could you keep an eye on him? And equally, it flows up. He reports back. So there's an end-to-end communication flow there. But people may be involved in feeding farm animals, planting the harvesting crops, repairing fences or maintenance work. They're assisting the chef in the kitchen and learning cooking skills. They can be serving meals.

Working in the farm laundry. Cleaning, weeding gardens, harvesting apples and making cider. Working in the woodwork shop. Working in the farm bakery, and so on. There's a whole lot of things you're going to get people engaged on, and behind this is the strategy that we don't want people sitting around. They are finding that you've got to get people up off their butt, basically, and out doing some kind of work during the day, because it's setting a pattern for an organised lifestyle.

PROF KING: Just keeping my eye on the clock, because obviously we need to be fair to all speakers.

DR KENT: All right.

PROF KING: We've got the submission here, which you're running through. Could we actually jump forward to p.23 of your submission, which is really the recommendations.

DR KENT: Yes, yes.

PROF KING: So, we've got the material that you've provided on the benefits of the restart farms. You've got three recommendations here. Perhaps if you could talk briefly through those.

DR KENT: All right, okay. Well, if we're going to - can I just say briefly, at p.22, if we're going to set things up, we've had an architect doing some sketches of what it might be. Broadly speaking, to set a facility up for 80 residents, it is more cost-effective to have a large than a small. It's about $20m. A couple of million dollars to buy the land, $20m ball park to construct the facilities, and another $3m to - for initial staffing. You've got to set up all your systems, all your processes, your training and so on, before you open the doors.

So we think about $25m to get one of these up and running, and the operating costs are based on staff ratios. You've got to have about a 1:1 staff ratio, because if you don't, you can't provide the services. You can cut that back. Now this is going to work out to about $100,000 per head in one of these places, but it's a little bit less than prisons, which I think are about 110,000 a year, and a lot less than acute hospitals, which might be 400,000 a year. So, coming on to the recommendations, we're saying that we believe it is worthwhile setting up such farms in Australia, and that's why I'm working on this charity to get things going.

Establish an appropriate funding model. Maybe the Commonwealth could provide funds, capital funds, to develop say two farms initially as pilot farms, one in Victoria, one in NSW, and eventually up to about 12 or 14 farms to get of the order of 1,000 beds here. I noticed in your report there was a shortage of post-acute beds, or non-acute beds, et cetera. This is one way to fill that gap, and we could add one extra farm per annum. But I don't know exactly the right funding mix here. That's far more your domain than mine.

MS ABRAMSON: Dr Kent, could I ask you, how are they funded in America?

DR KENT: Look, it's totally different. They have to be mostly private paid, because the government doesn't kick in the money, basically.

MS ABRAMSON: So they're philanthropic funding?

DR KENT: Yes. Yes, they do get that, and it's the reason they haven't ballooned out into a large number. But there's a cut-off that only five per cent of the population can afford to go there, because their fees are 300 to US$500 a day. So you're paying $10,000 a month or more, depending on their own staff ratios. They do extensive fundraising and philanthropic work, and thereby they can give people 20, 30 per cent remission on fees, depending how the fundraising's going. But that's one of their ongoing issues.

But if we have a different health system here, we may be able to get the bulk of the costs covered by either some sort of government grants or funding, and then philanthropy would play a smaller but important role.

PROF KING: Could I follow up on that? For us to make a recommendation such as the one that you've got here - I agree completely, but the $100,000 per person per year is a lot less than - because it's about $120,000 last time I looked.

DR KENT: Okay.

PROF KING: It happens to be an area I've worked in, and obviously much less than acute hospitals. But that's not really the right comparison.

DR KENT: Okay.

PROF KING: The comparison is the cost-effectiveness of the Restart farm approach versus the cost-effect - cost-effectiveness, I mean. How effective are the facilities, the residential services, essentially, is what they are. How effective are the residential services at meeting the outcomes for the consumers versus the cost.

DR KENT: Yes, yes, yes.

PROF KING: So that's what I mean by cost-effectiveness here.

DR KENT: I can respond on that if you'd like.

PROF KING: Please. Yes, and particularly if there's been an evaluation. You mention the Gould farm here, and you mention its absolute outcomes, but you don't mention relative outcomes compared to alternative residential services, in-community residential services.

DR KENT: No. I haven't had a look - had a chance to do that comparison yet. But they do a lot of work on measuring outcomes. They use a number of psychiatric measures like the GAF, which I think is the Global Assessment of Functioning, and other ones. And there's no way someone goes from very sick to very well, that's not in the question. But some of them - they all report - get outcomes. They usually have universities engaged to evaluate these with proper statistics, you know, and psychologists working on it, professionally done, and it's on - a lot of it's on their website.

If they get someone move in - coming in with a GAF score of 45, which means pretty low functioning, and go out at 60, that's - in these terms, that's a significant gain. When they move out to transition out - as they transition out, there's a step down model - they can improve after that as well. But that means they have improved their social skills, they've - their symptoms have abated somewhat. It means that their personal life is better organised. It means they're more work ready.

So there's the qualitative outcomes, and they feel better in themselves, by the way, too. And part of the evaluation is, what do the families say? And the families are pretty enthusiastic about it, so much so that some of them come back and say, look, we're going to give you a $5m donation. I mean, that kind of thing speaks for itself. So they have the formal and the informal measures of outcomes, and yes.

MS ABRAMSON: Do they deal with substance use disorders as well? (Indistinct).

DR KENT: Yes, some of them do. Yes, some of them do, and they don't all do that. I'm thinking here in Australia, that is something we would need to add on subsequently. Initially, I think there's enough to focus on just to get things going, right. But that, no doubt, would arise and have to be addressed. Yes.

PROF KING: Good. Okay. Thank you very much for that. If, as I said, our recommendation at the moment is quite deliberately general in the sense of there needs to be more residential services, particularly for people found with severe - when they're moving out of hospital, moving out of hospital community-based services in - hospital-based services into community-based services, and we deliberately haven't, in a sense, approached it the way that you say, well, I'd like a recommendation on Restart farms.

For us to go that extra step and say, Restart farms as a specific recommendation, we do need that evidence to show that, not just that they're reaching outcomes, but they're reaching better outcomes than an alternative.

DR KENT: Okay.

PROF KING: So we'll look up, obviously, the Gould Farm material that you've mentioned to us. Again, if there's any other material that you come across that is able to answer that question, then that would be extraordinarily helpful.

DR KENT: Okay. I'll look into that, and perhaps I can send it to you if I - - -

PROF KING: If you could.

DR KENT: - - - if I find it.

PROF KING: Absolutely.

DR KENT: Yes, all right. Thank you very much.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you very much.

PROF KING: And I will look at Miriam. You need a copy. This is a formal submission, as an electronic copy. Would you be able to - yes. If you could just liaise with Dr Kent so that we can get an electronic copy.

MS ABRAMSON: It's very organised.

PROF KING: Next, we have Elizabeth - try again. Sorry. Grab some water, I think. Elizabeth Yared and Fiona Costolloe, from Launch Housing. And again, whilst I've already said it, if you would be able to state your names and affiliation for the transcript, and then if you have any opening comments you'd like to make.

MS COSTOLLOE: Thank you. So, hello. My name is Fiona Costolloe. I work at Launch Housing as a group manager of our permanent support programs.

MS YARED: My name is Elizabeth Yared. I'm an intensive case manager in a program called Complex Care. So I work with people who've been chronically homeless, with complex support needs, including severe mental illness.

MS COSTOLLOE: So I guess we'll just perhaps start with a brief overview of Launch Housing. Launch Housing is an organisation providing support and accommodation to people who are homeless or experiencing homelessness, or who are at risk of homelessness in metropolitan Melbourne. Launch has about 14 sites and approximately 400 staff members, and we work closely with people in the community to support their transition into affordable, secure, safe housing, and to work with them during that time, in a lot of cases, around their mental health support needs.

We work quite closely with a lot of different parts of the mental health service sector, so whether that be acute clinical settings, clinical support services, or community mental health support providers, GPs, and the like. And then we also have a number of programs that have a specific mental health focus, where we're working very specifically to address the mental health needs of that particular person who's homeless, or at risk of homelessness. Go for it, Liz.

MS YARED: I suppose what I can offer is what the interactions between housing and mental health actually look like on the ground, and then I'm quite happy to take questions on the draft recommendations that you've made. I suppose, in terms of people with mental illness interacting with the housing system, and mental health services interacting with the housing system, I think any recommendations really need to take into account the severe shortage of social housing. It's very difficult to do something like formalise a policy of no exits into homelessness from institutions without the actual resource to back that up.

I understand that that's beyond the scope of your inquiry to fix the housing system. It is a challenge though that perhaps any policies like that would not be effective if we were not to address that actual resource that's needed. If you are in acute mental health, if you are, say for example, in (indistinct) unit, the discharge plan for you is likely to look like either going straight to an entry point - Launch has several entry points where you can present.

It's like a shopfront style service. It might look like the hospital arranging a rooming house, which is unfortunately another form of homelessness, and particularly unideal for people experiencing severe mental illness. Or it may look like short-term accommodation, either crisis accommodation or emergency accommodation in a motel until the most likely outcome, which will again be a rooming house. So I think that that stock issue, while I understand is a bit beyond the scope of your Inquiry, does really need to be addressed if we're going to address people's mental health.

It's very difficult for people to start their recovery journey if they don't have a stable, secure and affordable place to live. And then I think the other side of that is when we have been able to find people suitable accommodation, the experiences of people who have been homeless interacting with the mental health system can be quite challenging. My team sees a

few sort of different key issues. I think the availability of ongoing clinical case management is quite limited, and it can be quite difficult to access that resource.

The type of support is very inconsistent beyond different catchment areas. So you may have assertive outreach and outreach case management in certain areas. Somebody transitions to a different area. We may have found them housing, which is great. There may not be the equivalent support commensurate to their needs, so it may - might be a sort of an appointment based, clinic based service, whereas previously they were receiving an assertive outreach service, which they really required.

And then I think the rigidity of the catchment based system, I think it's difficult to completely abolish that. I can't really see a system operating without catchments, but the transition points are particularly poor. People are closed very quickly, and it takes a long time for them to be picked up by another service. So I think perhaps the Productivity Commission could look at those transition points, and how different catchments are working with each other.

And then I think it's been touched on by Mind Australia, from what I heard briefly coming in, the transition of community mental health to the NDIS has had an impact on our client group. It was previously a low barrier to access. People who were not able to access other types of mental health support, like clinical case management, or attending a GP, were able to receive that recovery focused community mental health support. That's now with the NDIS, which has quite a high barrier to access, and multiple barriers to sort of jump - jump through, which makes it challenging for our client group.

MS COSTOLLOE: Yes, particularly challenging when you're homeless.

MS YARED: Yes.

MS COSTOLLOE: Or transient, and you're struggling to meet daily requirements, let alone going through a formal process of assessment and, you know, making appointments to go through the application process and assessment process of the NDIS.

MS YARED: Yes. And then there's sort of a lack of assertiveness with certain NDIS supports. So for people who are particularly hard to reach, that might not be the most appropriate service, whereas community mental health sort of fared a bit better previously.

MS COSTOLLOE: I think, in regards to the NDIS, and supporting our client group to access the NDIS, what we've found is the best way forward in a lot of cases is to resource our staff group appropriately, with basic knowledge and understanding so that they can provide that assertive outreach support to bring people along for that journey of going through the assessment and application process, and touching into the clinical service system with the support of our teams, because that proves to be more effective for those people who are struggling to work through that complex system.

I think, other than that, we just wanted to, I guess, support the recommendations around the need for Housing First approach, and increased focus on Housing First and long-term housing options for people with chronic, persistent mental health issues, as well as the need to have a focus on sustaining tenancies as an early intervention approach in regards to mental health,

and ensuring that people don't go further down the track towards chronic mental illness, and just, I guess, the co-occurrence of mental health and homelessness being a strong focus in the draft report is very much welcomed by Launch Housing, in particular.

PROF KING: Well, you've said what you like our - okay, so I'm going to ask you the sort of, almost the obvious question, the important question, which is, you've said what you like about our recommendations; what recommendations, other than fixing the housing system, which we'd love to do, if there was - I was on another inquiry where we were trying to sort of do that, but that's another - that's a different story. What recommendations, what specific recommendations do you see that we haven't got that you think we need?

MS COSTOLLOE: That's an interesting question.

MS YARED: I think I probably talked about tweaking the recommendation 15.2, no exits into homelessness. You know, and I've already stated, it's very difficult to do that without the housing stock. There are some things that may ameliorate that a little bit, so I'd like the Productivity Commission to look at existing programs that are usually run in conjunction between housing services and inpatient unit that are working quite effectively. There are a lot of those across the country. We have one with the Alfred and one with St Vincent's called Housing Mental Health Pathways Program, HMHPP, and it provides that continuity support from the inpatient unit into the community.

It's usually short-term case management finding accommodation and stabilising that person in the community. So I think that perhaps looking at some of those programs that are effective would be a good way to sort of formalise that policy. I would worry about simply having a policy that says, you can't exit someone into homelessness without having that - that particular, very clear support of what that would look like.

PROF KING: The implementation.

MS YARED: Yes. Exactly.

MS COSTOLLOE: And the need for step down approach as well with that, where it's intensive, but also that it's something that can follow people through their recovery journey, and to make sure that that housing stability is something that is managed and maintained. I think there's a lot in the report around sustaining tenancies, and there is quite a number of great programs, including Tenancy Plus, Support for Families at Risk of Homelessness that Launch is involved in.

But there's a need to look at what's available as well for people outside of social housing. There is the Private Rental Access Program plus that is going to be rolled out shortly. It will be interesting to see how that can support a greater number of people around sustaining and not falling into homelessness, because as we know, that's a very traumatic experience for somebody, and particularly when you're already experiencing mental illness.

MS ABRAMSON: We're very interested in a number of the programs that you talked about, and I'm assuming you'll make another submission to the Inquiry. If you could include them, and thinking particularly, we know that one solution doesn't work for all, that there might be

a number of different solutions. So specifying for us which cohort of people you think that a particular program has been very successful with, that would be very helpful.

MS YARED: Certainly.

MS COSTOLLOE: Absolutely. Yes.

MS ABRAMSON: I wanted to ask a question. You said before about the transition, and people in the housing system actually falling between catchments, and we're particularly interested in this, because we've been thinking a lot, in another part of the report, how people access services, and we've been thinking about the current model of PHNs and LHNs. So really interested in exploring a little bit more what you've said about that transition issue.

MS YARED: Is there any specific - - -

MS ABRAMSON: In terms of your actual, practical experience. That somebody is in a particular service, they move to another state, or even across the road; so how prevalent is that?

MS YARED: Very common, even at something as small as 500 metres. It does depend on, I guess, the individual case manager and service in terms of how good that transition is. Sometimes there's room for advocacy. Other times, it's very much, no, sorry, they're not in our catchment anymore, if they're on. And, you know, I'm dealing with a case at the moment that's quite high-risk where it's been a very clear delineation of, they've moved out of our catchment, but the other service has not picked that person up.

So we've got a period of three or four weeks of very high-risk mental illness, and no support, and sort of other workers involved who are not mental health supports sort being the quasi mental health supports. So, long story short, it's very common, but it does depend on the individual case as to how far a service will go to making a good transition.

MS ABRAMSON: Because we've thought a lot about care coordinators. So we have though a lot about the joining up of services. I mean, we've had a very narrow focus, because we've been thinking about people with mental ill-health, and of course, homelessness is a wide range of people. But any of your thoughts on how we can knit things together in a better way would be most welcome.

MS COSTOLLOE: We do have experience in regards to, I guess, Transition Support Program, previously PIR, where Launch Housing offered that sort of - that was involved in a consortium in the South Eastern Primary Health Network, where we working as - with a consortium where we were case coordinating people, and Launch specifically had a focus around people who were homeless who required that additional level of support, and it was very successful in supporting people to access the services that they really did need, and the care coordinator, Des, had a very good understanding of the language that was required to access that, as well as stepping people through quite closely, and working in a very good, collaborative, trauma informed focus. Yes.

MS ABRAMSON: Thank you.

PROF WHITEFORD: So, just one question. On the housing stock, some of the feedback we've heard is that clients with severe persistent mental illness who are accommodated, the challenge is the - I guess, supporting them in that environment, and the alleged impact on the housing stock itself.

MS YARED: Yes.

PROF WHITEFORD: Have you had that experience? And if so, is there a way to ameliorate that risk, if that's a real risk?

MS YARED: Are we just sort of talking about maybe antisocial behaviours, or damage to stock, and things like that, that would result in mental illness?

PROF WHITEFORD: Yes.

MS YARED: Yes. That's a daily reality of mine. I definitely think we need to look at the built environment for people with mental illness. I think something as simple as soundproofing certain stock. Yes, it is a tricky one, because we're always balancing the needs of the neighbours, who are often quite fearful, with the rights of somebody to remain housed and also receive the mental health support that they need. So it's a tricky question, but yes, it is a common issue and I do think we need to explore what sort of - what built environments are working for people with mental illness.

I think often high-density living is quite inappropriate for some people, so that, of course, has the added complication of increasing wait times if we are looking for medium-density. Yes.

MS COSTOLLOE: And I think Launch Housing is very keen for the Commission to consider permanent supportive housing options as recommendations in regards to longer-term housing options, because permanent supportive housing offers 24-hour supportive, you know, trauma informed care to people. It's secure, it's safe, it's affordable, and it can be done in scattered sites.

So you have a low-density option, it can, you know, it can also - but when you've got that 24-hour on site care, a lot of those risks can be reduced, when you're thinking about antisocial behaviour, damage, rent arrears, and those sorts of things, because you've got people there who are engaged with the residents on a daily basis, supporting them around their recovery goals, and offering - and there's, I guess, other support services linked closely to their housing, whether it's on site services or our Elizabeth Street Common Ground service has psychologists visit regularly, and we also have Alcohol and Other Drugs services who are on site, a nurse who is there most of the time to support people around all of those comorbidities that occur when you're homeless.

PROF WHITEFORD: If you were able to just, I guess, capture those learnings and experiences that you've had from running those services, and provide them to us, that would be gratefully received.

MS COSTOLLOE: Absolutely. That would be terrific. Thank you.

MS ABRAMSON: Did you have a - - -

PROF KING: No, please.

MS ABRAMSON: I have one final question, and it may not - I'm assuming that you have worked with people. Our recommendation about no discharge into homelessness also related to people released from correctional facilities, so interested in your observations, even if you want to take that on notice with the work that you're doing in that area.

MS COSTOLLOE: That would good. Yes, I think we do - yes, we would like to contribute something in our submission around that. I think that's very, yes, relevant.

MS ABRAMSON: Thank you.

MS COSTOLLOE: Thank you.

PROF KING: Thank you very much.

PROF WHITEFORD: Thank you very much.

MS ABRAMSON: Thank you.

PROF KING: And next we have Belinda Caldwell. The microphones are just for the transcript. If you could state your name and affiliation for the transcript, and then if you have any opening comments you'd like to make.

MS CALDWELL: Okay, thank you. So, my name is Belinda Caldwell, and I'm the CEO of Eating Disorders Victoria. So, I wrote some notes, if that was okay.

PROF KING: Yes, please. Please.

MS CALDWELL: So I'd like to talk to the draft Mental Health Report recommendations from an eating disorder's lens. At Eating Disorders Victoria, we represent the voices of those with an eating disorder and their families, as well as provide a range of support services. Our programs include peer mentoring, telehealth Nurse Navigation and care coordination support, support groups, and our hub service, which offers first line contact and support.

As many of you would know, eating disorders have one of the highest mortality rates of any psychiatric illness. Often emerging in adolescence or young adulthood, we know that prompt, comprehensive evidence-based intervention can change what can be a lifelong, chronic, debilitating illness into a one-off episode or episodic illness which can be managed. While the evidence about what works is still emerging, we know that a focus on early intervention, care coordination, evidence-based treatment, support carers, and appropriate responses from hospital are key.

Early intervention is key to detecting eating disorders early and onset, and acting aggressively to shorten illness duration and improve long-term outcomes. There are online assessment

tools, like Feed Your Instinct, for concerned families, and Reach Out And Recover, for those who are concerned about themselves. They should be part of any overall plan, so not just online treatment options, but online assessment options.

So online treatment option work extremely well with bulimia nervosa and binge eating disorder, and we strongly support any recommendations supporting developing these and making them affordable and accessible. Navigation of our eating disorders service system currently can present a nightmare, complicated often by the fact that someone who is unwell with an eating disorder experiences high level of treatment ambivalence due to anxiety. It often falls to the families and carers or others to find services, negotiate treatment access and support, or even allow the person into treatment.

Better service coordination and simpler care pathways would assist carers as well as clinicians. So we support the recommendation around the single care pathway, but just want to note that health pathways does not currently allow non-clinician access. So any solution would need to address this. Evidence-based treatment in young people predominantly relies on families and carers to do a form of hospital in the home, which requires around the clock care to refeed their young person and interrupt compensatory behaviours, until such time as they are able to eat and exercise appropriately.

There is emerging evidence that similar approaches in adult treatment may also improve recovery rates. However, the impact of this level of caring on families is significant, financially as well as emotionally. Research indicates that families of someone with an eating disorder have extremely high levels of carer distress, often associated with anxiety and depression themselves. To reduce carer burden, we'd recommend much higher levels of support for families.

In terms of building skills and knowledge on how to care, much stronger integration of carers into assessment treatment planning and discharge processes. Recovery for someone with an eating disorder is much more likely if they are robustly supported in the home environment for a significant amount of time, and carers require educating in areas such as meal support, distress tolerance, to increase self-efficacy in reduce burnout.

We support the recommended changes to the carer payment access, as many of our community have found this difficult. It should be noted that generally the carer payment support is poor recompense for lost income and the costs of the illness. Effective respite options, skilling of schools to do meal support, awareness of workplaces of the practical requirements of refeeding a loved one are also some of the supports that are needed.

Hospital in the home options are only briefly mentioned in the report, but would be an effective treatment option for those with an eating disorder on discharge from hospital, to reduce the all too frequent relapses. One of our concerns are where there is any separation of mental health out from physical health. People with eating disorders often require both medical and psychiatric care, and the universal experience is that the different systems can do their part well most of the time, but not the other.

In the outpatient setting, the person will need medical monitoring and dietetic support, alongside the psychological therapies. Currently, in the hospital setting, if someone is in a

medical ward for medical stabilisation, clinicians can be unskilled at meeting the mental health needs of that person, and when in a psychiatric facility, the person's nutritional refeeding requirements are often not met. When people are significantly malnourished, they can experience higher levels of suicidality and anxiety, and nutritional rehabilitation is key to their mental health as well as physical.

Finally, specifically from an EDV perspective, we are concerned that the role of NGOs in mental health is not delineated strongly enough in the report, and are unsure where they fit in the rebuild model. We provide key services for people with mental illness, especially in the peer mutual self-help space for both those with an illness, and their families and carers. Our funding is majorly provided by the Victorian state government as a single funder, and we would ask that any final report recommend reliable, sufficient, and simple funding streams for this vital part of the mental health system, and avoid any unintended consequences in any recommendations.

PROF KING: Just a very, well hopefully, a very simple one, and then I'll pass on to my colleagues.

MS CALDWELL: Yes.

PROF KING: And this may again be something that the team knows, but not something that I've realised. You mentioned online assessment and treatment for eating disorders.

MS CALDWELL: Yes.

PROF KING: And I guess, behind it - I understand completely the sort of triaging part that needs to be involved in any online service, but you said the online treatment works well, which did surprise me for eating disorders, having talked with, I suppose, some of the (indistinct) and carers, or people with lived experience, I guess, like (indistinct) and carers, about the issues of recognition by the person of their disorder. So I was quite surprised when you said those online - that online treatment works well, so do you mind expanding on that?

MS CALDWELL: Sure. I think probably what happens is that a lot of the voices that people hear from, and we're as guilty of this, is really referring to anorexia nervosa, which is actually the rarest of the eating disorders. So for bulimia and binge eating disorder, there is a lot more motivation from the person to get better from those illnesses.

PROF KING: Okay.

MS CALDWELL: And we do have really quite strong evidence, both in face-to-face and online, that aversion of cognitive behavioural therapy for those two conditions are very effective. And in some ways, the online option is less shaming for them than actually, you know, going to see a psychologist about it. So I am referring - I'm not referring to it in terms of anorexia.

PROF KING: Yes. Okay.

MS CALDWELL: That's all right.

PROF KING: So it was my misunderstanding. So please, Harvey, would you like to?

PROF WHITEFORD: So with the MBS side changing, what's the reception from the sector with respect to their value and the - what you can cover through that sort of treatment versus broader needs that the client group are going to need?

MS CALDWELL: I mean, I think they're already making a significant difference to access to psychology and dietetics. We're obviously in very early days to see how it all plays out, but I think, you know, there's been - long been a need that if someone is going to have therapy, evidence-based treatment for eating disorders, that they need more than the 10 visits under the old scheme.

I think what is yet - still need to be sort of worked out, I guess, is when someone really needs that even more specialist, intensive part of treatment, and what we don't want to see over time is public sector programs going, okay, well these guys have now got an MBS item number, that can happen out there. Because it still is pretty tricky for an - a fully outpatient team. If someone's really unwell and may need hospitalisation, or really intensive supports for their families and carers and, you know, and it's a really, really, serious mental illness, that generally is better provided in our public system.

PROF WHITEFORD: And I guess the support for the family component, because they're often a younger adolescent, for example, are there services available for the families?

MS CALDWELL: There's not a lot. So, what we've seen, particularly in the adolescent thing is a real shift to family-based treatment, which it has been most evidence-based at the moment for effective treatment, which relies fully on the family being at home, doing all six meals, 24/7 care for extended periods of time. Which has been great, compared to parents previously being kept out of the treatment, but it - there's not a lot of support. Some public services are looking at additional cycle education for families, support groups. There's not a lot outside of that. And particularly in terms of respite or anything like that, there's really none.

PROF WHITEFORD: Okay. Thanks, Stephen.

MS ABRAMSON: Could I ask a question about the peer mentoring program? We're very interested - - -

MS CALDWELL: The what, sorry?

MS ABRAMSON: The peer mentoring program.

MS CALDWELL: Yes.

MS ABRAMSON: We're very interested in the role of peer workers and what more we can to do to support that. So very interested.

MS CALDWELL: We've had a peer mentoring program for, I think it's three years now. Essentially, it started off as a philanthropic funded program, and has morphed across to being a DHHS funded program, because it's been very effective. Essentially, it's for people coming out of hospital or a day program, and it provides them with three hours a fortnight with someone who has fully recovered from an eating disorder. And they do a whole range of things. They can go out and, you know, have lunches or they can, you know, just hang around and chat or they can go for a gentle walk somewhere, or something.

But the idea is that that person provides mentoring for that - and what we've found with that is there's a whole lot of stuff that has to sit behind that, but what we have found that is we've really significantly reduced hospital readmissions, and that's hence why the state government ended up taking over the funding of it. Does that answer the question?

MS ABRAMSON: Yes, yes. Well, one additional issue. I was just interested in the words you said about someone who's fully recovered. One of the issues we've been looking at with the peer workforce is the type of capabilities and skills that a peer worker needs to actually have. So I'm assuming you've got quite a screening program and a - - -

MS CALDWELL: I mean, it's a little bit arbitrary in some ways. We require people to have not engaged in any eating disorder behaviours for at least two years. On top of that, you know, it sounds - I don't know, it sounds overly bureaucratic possibly, but we screen both the participants and the mentors with something called the EDE-Q, which is our eating disorder assessment tool, and then we provide quite robust support for both the participants and the mentors behind the scenes, with our own staff.

So if the mentors are ever triggered or concerned, they've got an open line to the - and we're actually proactively going into look for that and support that. I think it's an interesting scenario, where we - yes, to how - my view is we're better off managing that risk than avoiding doing the peer mentoring.

MS ABRAMSON: If you were intending to put in another submission, and I hope you are, we'd be quite interested in having some more details about that program.

MS CALDWELL: Definitely. Will do.

PROF KING: No.

MS CALDWELL: Thank you very much.

MS ABRAMSON: Thank you very much.

PROF WHITEFORD: Thank you.

PROF KING: Next, I'd like to call up Dr Ann Moir-Bussy. Good afternoon, Dr Moir-Bussy. If you could state your name and any affiliations for the transcript, and any opening comments you'd like to make.

DR MOIR-BUSSY: Thank you. I'm Ann Moir-Bussy. I'm the Vice President of the Australian Counselling Association, but I'm here today speaking as a private practitioner, as a counsellor. Thank you. I've been a counsellor since 1992, and working in private practice. I've also worked with the Social and Emotional Wellbeing centres in the Northern Territory for a number of years, at Darwin, Katherine, and Alice Springs, and helping the Aboriginal counsellors to develop - and I also developed a diploma in Aboriginal Family and Community Counselling at the University of New England, and for five years, helped them to work.

Over the years, many mental health problems that have been quite frightening in those areas, quite sad, where people cannot access the help that they need. Your report, I think, is really great. I was at MBS meetings in the last 12 months in Canberra, and where there was a lot of discussion around the provision of mental health services for people who most need it. One of the things you talk about is there's not enough early intervention, that's preventing people - that's helping people from developing long-term mental health problems.

And I think part of the difficulty is that we as counsellors are left out. We're not recognised for our qualifications, for our training, and for what we can provide for those people. And as a private practitioner, this is really one of the hard things for us, particularly for me when I have to turn people away. People who come to me with depression because of divorce, relationship problems, suicide, looking after Alzheimer's in their family. People who are really suffering, and I can see them for nothing, but we don't get support and they don't come because they can't afford to come.

And I think this is one of the things missing in the report, where allied health professionals are listed rather generally, but counsellors are not included in that, and I'm talking about registered, qualified counsellors. I'm not talking about just anyone who hangs up a shingle after a weekend of training. I'm talking about people who have that long service and long commitment to people. Over the years, I've dealt with a lot sexual abuse. I live in Ballarat at the moment, where I've set up a private practice. I've retired from teaching at universities, and live in Ballarat. There's a huge area of sexual abuse that needs to be addressed there.

A lot of people suffering from that, and I've run lots of sexual abuse programs that help people heal from that. We are unable to provide those - we can provide them, but they can't afford to come, and this is the sort of thing, I think, that the Commission really needs to look at, to give this opportunity that people can have that choice of going to the person that they want to go to, or getting the help that they want to get without having to go through a long waiting process, or being told they have to see a qualified psychologist or a psychiatrist. That's certainly needed for people who are really, really sick. But a lot of people in the early years don't need that. Any questions?

PROF KING: I'll open it up to my colleagues first.

PROF WHITEFORD: So, I guess the scope of practice for the counsellors, how would you see that fitting into that? You've probably seen in our report, we refer to the Stepped Care Model of service provision. Have you had some thoughts about where counselling and (indistinct) fits into that sort of a - - -

DR MOIR-BUSSY: We certainly feel that we do fit into that model, not just in the very early intervention, but also the moderate, and being part of a disciplinary team in the complex care provision too. I was in Argentina a few years back where there was a good example of that psychiatrist, psychologist, counsellors, massage therapists, all working together in one system. And that kind of support that was needed was really valuable to see.

PROF KING: You mentioned MBS, and I mean, which is sort of the elephant in the room, if I can put it that way.

DR MOIR-BUSSY: Yes.

PROF KING: In some ways, our recommendations though, we've not looked at expanding MBS services. If anything, we've made recommendations over time that, for example, down that moderate acute end that it could (indistinct). It depends on the evidence, but it could potentially move to more commissioned services, while at the mild end, we're looking for moderated online type of services.

So, I guess my question is, in a system where we're moving online - moderated, online at the low intensity, more commissioning of services up at the upper end, where do counsellors fit in, and if - is it really necessary for the counselling workforce to be part of that MBS, which does open up a - I understand it opens up a bucket of funding, but it also opens up a bucket of expense from the taxpayer's perspective.

DR MOIR-BUSSY: We're mental health practitioners, in that sense. We've studied mental health. We're trained in mental health, in psychology. I do a lot of focus on positive psychology, which helps people to move forward in a much more positive way and get to where they want to be. Online programs, we're very familiar with online programs. I do a lot of counselling online, by Zoom, by Skype, helping people that way. And there's a place for counsellors who are trained in all the - we're trained in CBT, we're trained in all the things that psychologists offer at that level.

There's a space for us to be able to provide, particularly in regional and remote areas. Areas where there's not access to psychologists or to counsellors, and I'll give you an example. I had phone call just the other day from a couple who are older who wanted to access counselling services. Their marriage is a little bit shaky because they're getting older and they can't handle it. They wanted help, but I didn't have MBS, so they can't come. They said they have to wait a long time to see a psychologist. And they looked up our qualifications, what we do. I get this quite often. So there is a place.

PROF KING: Do you see counsellors as being, in that online space, which would be - I'm not sure if you're familiar with PORTS over in Western Australia, but that a broad online program which would involve both assessment and the delivery of - assisted delivery of online counselling services, CBT.

DR MOIR-BUSSY: Yes, very possible.

PROF KING: Yes.

DR MOIR-BUSSY: Some of this do this already.

PROF KING: So do counsellors have a role in there?

DR MOIR-BUSSY: Some of do this already, but without any support.

PROF KING: You mentioned as part of teams. I mean, again, that's - I guess our recommendation is to look at that through commissioning. Is that an approach that you think is appropriate, or?

DR MOIR-BUSSY: It is appropriate, in a team. But I think the other thing I'm saying is, as private practitioners too, while we can work in part of a team, there's - we have over 5,000 members. That's a huge workforce that's being ignored when people are in need, and I'm thinking of the consumer more than just what we want. There's so many people just longing for help and not able to get it.

PROF KING: Other comments?

MS ABRAMSON: I just want to ask, and you might want to take this on notice; you mentioned before that you had worked with Aboriginal communities, and we have a number of recommendations in terms of support services for Aboriginal Australians, so I'm just interested in your experience, particularly in that counselling, mental health space, and training up an Aboriginal and Torres Strait Islander workforce.

DR MOIR-BUSSY: Yes. When I was training them, we would have had about 20 in four cohorts over the time I was there. 20 in each cohort, and a lot of them have kept in touch since then. They need to be trained from that cultural perspective so that they - they're able to use their own ways of working and then able to use their own traditions of working with people within their own communities, and they found that really, really important. I still get requests from them when I come sometimes and work with them in that area, and I'm not able to do so now because of where I am.

But I think that's a very important area, where more training is provided for them and more support is given to them so that they can actually work better. That training program has gone now from the university, and only last year, I had requests from some of the original trainees. Their communities still need it, and would we develop something else for them, which I'm not in a position to do now, but that sort of need is still there for those Indigenous people.

MS ABRAMSON: Do you know why the program was discontinued? Was it a funding issue, or - you don't have to say, if you'd prefer not to.

DR MOIR-BUSSY: I moved to Hong Kong to teach for five years, and then I think the person who took it over didn't want to keep it going. It's one of those things that happened within, you know - programs come - and I was training people in Hong Kong at that stage, so it was a bit different.

MS ABRAMSON: No, look thank you very much.

DR MOIR-BUSSY: Thank you.

PROF KING: Okay. Thank you.

DR MOIR-BUSSY: Thank you.

PROF KING: So the next person we have is Michael Blair. Michael, if you are able to state your name, affiliation, and - for the transcript, and any opening remarks.

MR BLAIR: My name is Michael Blair. I'm a retired specialist mental health nurse. I have 45 years working in Victoria, Queensland, NSW, ACT. Mainly down the east coast, and I've worked in management planning across ministry in NSW, and also in trade union movement. So I have a broad scope, if you like. Now retired, but passionate about mental health, and specifically specialist mental health nursing and its future.

And my soapbox, I guess, is that the recommendations made in s.11.4 in relation to workforce I fully recommend and commend the Commission for its insight into what are some of the solutions for the future workforce, and specifically in relation to specialist mental health nursing. I see, throughout my career, mental health nursing as being devalued and its expertise is being ignored, and I think the only way that we can avert that is to return to and revisit specialist mental health nurse registration in this country.

It was something that we valued and we lost with the national register and APRA, and because mental health nursing is a small minority in the scheme of things, in the overall nursing workforce, we are a mouse that roars and we are roaring at the moment because we see that our skills are at threat, and have been for some time. A number of facilities are now employing nurses without skill to fill the spaces that they are unable to fill with nurses with quality and qualifications and expertise in mental health, and that is leading to some of the safety issues that we see and some of the quality issues that we see that are disappearing from our mental health sector.

Another soapbox that I have is the national - the Mental Health Act, and I've had experience as a mental health tribunal coordinator in one position that I held for some time, and I have been a party to a number of reviews of Mental Health Acts in different states, both Queensland, ACT, NSW, and Victoria over the period of my career. And having worked in the ministry, I've also seen the number of bureaucrats that are employed to oversight memorandum of understanding to ensure that the gaps in service, as people transition from one state or jurisdiction to another, are required to ensure that their treatment is continued.

And the amount of money that goes into ensuring that that takes place led me to think that wouldn't be nice if we had a national Mental Health Act. Now, I understand that from a constitutional perspective, this is a big ask, but we have been able to see overarching acts of parliament and state jurisdictions and territories still maintain the quality in the service provision and overall management of the tribunal and the act within their - each state.

But it then provides us with this overarching ability to reduce the number of reviews. Every time we have a need for a review of mental health legislation, we go through a whole process,

there's an enormous amount of funding that's allocated to oversight that review and the formation of the new legislation for each state or territory. And those reviews are necessary, but wouldn't it be nice if we had one review that would be overarching, and if we're looking at ways in which we can be more productive, then this is an opportunity, and when we can say, look, wouldn't it be great to have a national Mental Health Act, it's a soapbox that I often stand on, but it is something that would be ideal.

There's a couple of other points that have been raised that I'd like to address while I'm here, and I have made some notes. One of the issues that I raised at the Victorian Royal Commission into Mental Health when they asked, what is it that you think works well, one of the positions I held was coordinator for the Second Psychiatric Opinion Service. It is an independent psychiatric evaluation of those that are held compulsorily under the Mental Health Act in Victoria. It's a requirement under the Victorian Mental Health Act.

It is not a requirement in other jurisdictions, as I understand, having worked in Queensland, NSW, and ACT. But it is a service that is provided here in Victoria, and it provides the individual with a plain language explanation and recovery plan in a written language that they can understand and that they can share with their relatives about why it is that they're being held under the Mental Health Act. Often, people that are held under the Mental Health Act against their will feel as if they've reached a dead end.

They've got no way of getting a second opinion, other than from internally within the service, and often an independent psychiatrist that is available and has the specific purpose of giving them a plain language explanation as to why they are under the Mental Health Act, gives them hope. And it is one service that I think is - it's not spoken of enough. It does work well, and it needs to be commended, and if it could be rolled out across the nation as a service for consumers, I think it would be of value. So I give that a plug.

I think, just reflecting on previous contribution to the Commission, Indigenous mental health is an area that I also have some understanding of. I'm pleased to see that Frank Quinlan has now been allocated the position of CEO of the Royal Flying Doctor Service, and I think that the positions of mental health nurses working in that service is something that we also need to promote. They provide consumers that are in remote communities with a service that is another gap in services that we understand is there. But the other valuable resource is trained Indigenous mental health workers that understand culture and understand the needs of our Indigenous and Torres Strait Islander communities. And I think that they've been undervalued.

Undergraduate direct entry; another issue that was highlighted in, I think, your recommendation 11.4. I have recently, at the Australian College of Mental Health Nurses Conference in Sydney, put a motion to the floor that we should return to undergraduate direct entry. I know this is - my colleagues from the ANMF don't see that this is of benefit, but I see it as being one of the ways in which we can ensure a future workforce, and I know that Professor Brenda Happell has a curricula that is already written and available for any universities that want to take that up.

Issue of mental health being provided to persons who are under remand in correctional services. Having worked with homelessness and in the area of corrections and forensic

mental health, my concerns are that persons that are held in remand have the ability to refuse mental health treatment and are not placed under the Act until they're released off remand. Often they are released into public mental health services, and are released when extremely unwell because they have not received treatment whilst in remand.

I understand that there are legal issues involved, but that it is of deep concern that if someone is of - in need of treatment and in remand, and can be in remand for a long period, that those people deserve treatment, and deserve treatment as should any other member of the public. And it places those persons that are members of the public in public facilities under serious threat, because they enter those facilities severely disturbed.

So I leave that with you as a comment, and I don't see a resolution. I don't know what the solution to that one is, because of the legal issues involved, but it is of concern to both those people that work in remand in the correction services, and also those people who receive those clients into the public facilities.

NDIS. Having worked with homelessness and trying to have people assessed for NDIS assessment, it is very difficult for anyone who is homeless, without ID, without an email, without an address, to attain an NDIS assessment. This needs to be addressed. There need to be specific people working in the NDIS sphere that have their role specifically to address those people who are in homelessness.

And on another note, in relation to housing and homelessness, I believe that there should be no discharge from facilities into homelessness. It is something that has occurred time and time again. It is something that has been somehow subtly accepted by the demand for, and pressure for beds, but that is not acceptable, and was never acceptable in my day, but it is becoming more and more obvious as we see more and more pressure for beds.

PROF KING: Just before I pass over to my colleagues, I just wanted to clarify something you said. You referred to people in remand getting treatment. You said people in remand can refuse treatment, mental health treatment, but then you said later on people on remand deserve mental health treatment. So is the issue that then - that people on remand are not eligible for the treatment, that they would receive treatment (indistinct).

MR BLAIR: Yes. There are people - - -

PROF KING: If you could just clarify.

MR BLAIR: Yes. There are people in remand that accept mental health treatment, and understand that they need mental health treatment. They have the insight to believe that they require a continuation of their treatment. But there are people in remand that are so unwell - and we do see severe mental issues presenting in remand - but their insight is extremely limited, and they can refuse treatment and become even more unwell and end up in isolation. And again, that's not a healthy situation either, whilst in remand.

PROF WHITEFORD: Sorry. So to clarify, the issue is the inability to involuntarily treat people - - -

MR BLAIR: Correct.

PROF WHITEFORD: **- - -** who are in remand, because they're held under - - -

MR BLAIR: Exactly.

PROF WHITEFORD: **- - -** a section of the criminal code, or whatever that state or territory has.

MS ABRAMSON: Yes. Yes, there's a legal issue. Whereas if they were subject to a community corrections order, or some other form, the court can actually impose conditions on that.

MR BLAIR: Yes.

MS ABRAMSON: But being in remand, they haven't - they have not been found - - -

MR BLAIR: That's right.

MS ABRAMSON: **- - -** guilty of the offence.

MR BLAIR: So the legal issues that compound their treatment, you know, that's the obstacle, and there is this position where, how do you resolve that, both from a legal perspective and from a medical perspective?

PROF WHITEFORD: Sorry, they're denied treatment that would, had they not been in remand, would have been provided with?

MR BLAIR: They would have been provided treatment.

MS ABRAMSON: Mr Blair, look that's been incredibly helpful. I was wondering if you might take something on notice, bearing in mind the time constraints.

MR BLAIR: Yes.

MS ABRAMSON: That Second Psychiatric Opinion. It doesn't have to be an extensive submission to us, but I'd be really interested in knowing a bit more about your work in that area.

MR BLAIR: Certainly.

MS ABRAMSON: Even a short submission. It just sounded - - -

MR BLAIR: The program is run between Monash Area Mental Health Service and NorthWestern. They have a partnership, so the service is provided statewide, and I can get you more detail on that service.

MS ABRAMSON: Yes, that would be good.

MR BLAIR: And it is supported by IMHA and the legal, and the beauty of that is that they can actually take a submission to a tribunal hearing and use that as evidence to the tribunal.

MS ABRAMSON: No, I'm really interested, because some of our recommendations actually go to the provision of legal or advocacy support for people before tribunals. So very interested in having a look at that model. Just mindful of the time.

MR BLAIR: Fine, thank you.

PROF KING: I was expecting you move onto the Mental Health Act.

MS ABRAMSON: No, I'm mindful of the time.

PROF KING: All right. Thank you very much.

MR BLAIR: Thank you for your indulgence.

MS ABRAMSON: Thank you.

MR BLAIR: And allowing me the opportunity to speak.

MS ABRAMSON: Thank you.

PROF KING: Thank you.

PROF WHITEFORD: Thank you.

PROF KING: Right. Now if we can break for lunch and perhaps reconvene at 1.30, I think would probably be the best time. So, thank you, and see you in 55 minutes.

LUNCHEON ADJOURNMENT

RESUMED

PROF KING: Let's reconvene the hearing, and the first person after lunch, Marie Piu.

MS PIU: Thank you.

PROF KING: And if you could state your name and affiliation for the transcript, and if you have any opening comments.

MS PIU: Thank you. My name is Marie Piu. I'm the Chief Executive Officer of Tandem, the peak body for mental health carers, or a trusted voice of family of friends in mental health, as we like to call ourselves in Victoria. We're also the Victorian member of Mental

Health Carers Australia. I believe you've already received testimony from Mental Health Carers Australia.

The focus of my presentation today is really a synopsis of what we've lodged in terms of a submission, and also some of the considerations we have as a result of reading your report. So there are number of things in the report that we commend, and there are some things that we note in the report that are, we believe, missing. And one of the major things that's missing in the report thus far is an understanding of relational recovery. We note that you refer to relational recovery, but there seems to be a disconnect between the words and the meaning behind relational recovery.

So when we talk about relational recovery, we're really talking about recovery that isn't based on the individual. The report very much talks about the consumer, the consumer, and the consumer, and I understand that. However, the reality is that people don't live as independent beings without any connections to others, and that doesn't come through in the report. So even though you've got quite a significant chapter on families and carers, it doesn't come through, and the understanding that interdependence is really the optimum that we're looking for, rather than independence, doesn't come through.

One of the things that that - why that's particularly important is that in Australia, and it's particularly in Victoria, about 25 per cent of the population have a parent born somewhere other than an English speaking country, and yet, it's not reflected in this document at all. I didn't get a sense that there was an understanding that recovery doesn't happen in isolation, and that unless the whole network around the person that has either the diagnosis of the mental health and wellbeing issue is supported, that that recovery is going to be sustainable.

The reality at the moment that we have, and particularly in Victoria, is that with the decimation of the community mental health system, we have a largely acute system that operates in crisis. It's not able to deal with the demands. GPs very much open - work from an individual model. They deal with the person in front of them, not necessarily communicating with family. There is an argument that perhaps when there are young children or teenagers involved, that's different. That's not generally the experience that we hear at Tandem.

So at Tandem, we are largely funded by the state government. Well, we're almost completely funded by the Victorian state government. We run something called the Carer Support Fund, which is a $1.5m fund that provides financial assistance to families where someone is associated with an area mental health service, and that's capped at a maximum of $1,000 a year. The reality is that it's so overspent, or so much in demand, that some services are putting in caps of two and $300 because they're unable to meet the demand.

So that's a discussion we're having in Victoria, but there isn't something similar that occurs in any other state, and also there's no opportunity, for instance, for families who are perhaps seeking help through primary health network programs, or through other means, to actually access any financial support.

So that's one thing. The other is that we've recently been funded for individual advocacy. We have something we call a carer support and referral service. In the report, we note that

you particularly talk about advocacy from the consumer perspective, and you talk about the likes of IMHA, where someone is a compulsory patient. The issue that we've found is that families are desperately in need of some support and advocacy, and we've been providing that both in the NDIS context through the transition support program at Tandem, and also generally.

And the calls that we're getting are around families being desperate, not knowing what door they can knock on to actually get support for their family member, usually - probably, in the main, they would be parents of teenagers who are suicidal, and who are basically being knocked back from all sorts of services, whether it be a Headspace, whether it be from clinical mental health services because they're not ill enough, Headspace because they're not - they're not sort of moderate enough, shall we say, or because they've got wait lists that are several months.

The community mental health services, of course, have lost their funding in light of the NDIS transition. So they're often not able to help, and a lot of the carers that are calling us are being told by the community mental health services they previously had support from, they can't be supported because there's no funding. So we're in that sort of no man's land in between. So the calls that we're fielding are very much around people feeling lost and feeling the despair that they're alone, and nobody seems to recognise that if it wasn't for family and friends supporting people with mental health issues, those people would not be able to maintain wellbeing when they gain it, if they gain it.

And so, we've got a situation, very much in the Victorian context, and around the country with (indistinct) counterparts that families are de factor case managers. They're often trying to sort out housing issues. Now, one of the things in the submission and your recommendations is that we very much welcome the changes to the carer support funding. That's very welcomed, but it's probably the only thing amongst your recommendations that actually stands out as something that's really positive from the family perspective, because you talk about things, you talk about family, but it's fairly empty for us.

So we're really needing to see more oomph. Now I know that individually you understand the role of families; it doesn't come through in the report. So we're wondering what we can do to assist in that process. You also talk about lived experience workforce. In Victoria, we're fortunate that we've got quite a well-developed lived experience workforce. We have carer lived experience workers. We're quite advanced, and we also have a framework, and I've brought a copy that I'm able to leave with you, which is a strategy for the carer mental health workforce in Victoria. It's a very, very good strategy.

You talk about piloting a system nationally, but we already have that system, so it would seem a shame to pilot something when we're actually running something in Victoria that has the makings of a good system. And the other thing that I would also observe is that the bias in the document is that it's very heavily biomedical, and whilst medicine plays a very important role, as a mother of a - as a daughter of a mother with serious mental health issues for most of my life, she's dependent on psychiatry to keep her relatively well, even though a lot of the side-effects she now lives with in her aged years are as a result of a lot of those medications. So I can resonate with what I've heard from previous speakers.

The reality is that we need to be thinking in a more contemporary way, and there are models in place, like Open Dialogue, and other systems in Victoria, and I'm sure around the country, that we could be investing in. But the document seems quite narrow in its focus. Is it that enough for now?

PROF KING: Yes. That's fine. Thank you. So I'll ask you the same question as we've asked some others in this situation. What would you want us then to recommend to the government to do? So not a statement about, well - along the lines, you know - because we all recognise families, friends, carers, are all critical for what we see as the consumer-centred approach to mental health care. We certainly don't see, and I presume you're not suggesting, there's a conflict there. There's just understanding. You have the consumer at the centre, and then you have the support network around the centre, and you have the other psychosocial supports as well as the clinical supports. But if we've got things wrong, or we haven't gone far enough, exactly what would you like us to recommend the government to do?

MS PIU: First of all, understanding what relational recovery means. That it's time to move from the individualistic model of recovery to one that's relational. So it talks about interdependence. I think that, particularly in a diverse society as we live in, we need to think about that in that way. If you're working with Aboriginal communities or multicultural communities, in which I've worked a lot, you can't work from that frame. The frame makes no sense. People are connected to either other.

And so, in order to support families, you need to provide them with support in their own right so they understand the experience. At the moment, as you would have seen in a lot of submissions, families are saying that they're excluded from information, they're not provided with support, all sorts of things. Even things like respite. There's a sense that respite is generic, but mental health families would tell you that respite needs to be provided in a mental health context. There needs to be understanding, and the staff that provide it need to understand mental health.

It's not enough for someone to just sit in a room with someone and - while you go out, because the family's not going to feel confident that that person is going to understand the context. So we have been involved in a lot of those conversations, so I think that thinking beyond the biomedical, and understanding its place, but understanding that we need to more contemporary in our approach to mental health and wellbeing. That it's about all of the things that, I guess, contribute to a meaningful life, and that means that people are able to access all sorts of modalities.

And I heard what Ken said earlier about the farm. Fine. It sounds like a great idea. There are a whole lot of contemporary models. I saw some in Yale recently when I was there. A model called Access where you have, for instance, paediatricians who are able to ring in and speak to a psychiatrist, a social worker, and a family peer worker, who can actually talk about the issues that are going on for the family, and then they follow up and make sure the person's been linked into services.

I know that the American model is different, because it's a fee-for-service model, but models like that are actually really good. We don't have anything like that at the moment. PHNs have potential to fund those programs. So PHNs, in their commissioning, it would be great to

have recommendations that when programs are being commissioned, that they understand it from a family point of view. At the moment, it's still very individual. Very individual.

PROF KING: I'm still having trouble understanding what you mean by individual versus family. I mean, my understanding of individual, that it's focused on the consumer. It's focused on the individual from the perspective of their mental health. But I don't see that in any way as being inconsistent with saying that individual is supported through their families, their friends, their network. That's a critical part of their recovery. But you seem to be putting those as alternatives. That if we say it's focused on the individual, or consumer-centred, then somehow we're downplaying them. I see that as a false dichotomy, quite frankly, so I don't understand what you're saying.

MS PIU: Okay. I think that perhaps I'm not being clear enough. What I mean is that obviously the person that is living with the mental health issue is at the centre of the conversation. But they don't live in a vacuum, and they have a huge impact on the people around them, and the people around them want to be helpful in the situation. But the supports are not provided for those people to be helpful, and often it actually causes destruction.

A lot of us have experienced families that have broken up and been destroyed by a situation that hasn't been - - -

PROF KING: (Indistinct).

MS PIU: **- - -** you know, that it hasn't been managed or supported. So that's what I'm saying. So it's just that often what happens is that it's about the individual, and the therapeutic approach is not to say, who are the supports around this person? How do we provide support to the team?

PROF KING: The supporters.

MS PIU: Yes.

PROF KING: Yes.

MS PIU: We just think about the individual, and that doesn't work, and the staffing services are really critically important. But they're not able to do their jobs either, because they're usually dealing in crisis. And they speak to us and they say, they have no time to spend with people in distress. They've got to get on and do their paperwork, and they've got to get on with things that they actually didn't sign up for when they did their training. Yes.

MS ABRAMSON: Can I pick you up on that?

MS PIU: Sure.

MS ABRAMSON: Like Stephen - and thank you for appearing today - like Stephen, I'm - it was never the Commission's intention that we had a view that there's the consumer, and it's all about the consumer, and we did take quite a lot of care with those carer chapters, to think

about what that looks like. But we're really interested in what are the concrete things that we can recommend? I take your point about advocacy support for families, and we have been narrowly focused. I mean, we've been thinking about in the mental health tribunal.

So, like Stephen, I'm trying to be quite clear about what are the things, apart from our recommendations on income support and carer support and payments, that practically you would ask of us?

MS PIU: I think that providing supports to families in their own right so that they can maintain the relational - the relationship they have with the person is really important. So I saw a model, for instance, in Israel called Nilarm, which is network of family services throughout Israel, and it's bipartisan, and it's funded and families can drop in there and they can be supported in whatever way they need to be able to continue in their caring roles with their family members.

I think it's about the mental health focus. So it's not a one size fits all approach to support for families, and I think that there's a real tension there for us that we hear from family members, because they feel that a lot of services are moving to a homogenous model. And the other one is online models. So another thing that I saw in the United States is there's a push back against online models, and the reason for that is that people want human contact. They want to be able to sit with someone when they're distressed and actually talk through and work through what the issues are.

So if we could have those sorts of programs funded, that would be very beneficial. I think the Housing First model that you propose is also very good. A lot of families talk to us about the fact that their family members are being discharged to homelessness. The reality at the moment is that unless people have families in their lives, that they're a much greater chance is they're going to end up homeless, in jail, or dead. And I hate to put it that way, but the reality is, that's what we're experiencing.

And so, if we don't support those family and friends to be able to actually provide the support they want to, and not become collateral damage, because I think the other side of it is that there's this taking for granted that people are just able to continue on with the sorts of distress that they're experiencing, and their family member experiences, and feel powerless to change anything, and that's going to be okay and they're not going to develop their own mental health issues.

So I think that's all very important. The other thing is that I think the proposal of GPs being able to see family for four sessions is a good one, and I see that you're looking at expanding - some of the recommendations are around also providing other supports under the MBS. I think that's very important. And also, the carer peer workforce. I think the expansion of the carer lived experience workforce, and again there's - we have a lived experience engagement framework in Victoria that talks very clearly around codesign and coproduction. I think all of these things need to be done in that context and so I can provide that to you so you that again. That's been developed, it's a very strong document, it's got buy-in from consumers, carers and services and again we don't need to be reinventing the wheel, these things are here and it's about designing responses that are actually going to meet the needs of the people who are critically at the centre of it which are consumers and their families.

MS ABRAMSON: Can I ask about CALD communities?

MS PIU: Sure.

MS ABRAMSON: We certainly, as part of our consultative process, met with a number of communities but what we'd really like to know is what type of recommendations, given the vast multicultural nature of Australia, what could we practically recommend for different (indistinct) communities and I'll give you a point in time: we've noted some commentary around organisations that provide phone support, that they're not as agile in terms of providing support for different communities so we are open to ideas in this space?

MS PIU: Obviously phone support will never replace face to face support. I did 11 years in transcultural psychiatry so it's my great passion. I also come from a multicultural family and I can honestly say that we tend to blame stigma for people not coming forward to use services but I think that's a cop-out frankly. I think it's because we don't provide services that are culturally appropriate or sensitive.

MS ABRAMSON: Yes.

MS PIU: I think if we provided - someone said at a recent conference we ran, 'If we get it right for multicultural refugee and Aboriginal communities we'll get it right for everyone'. We've really got to think the most marginalised communities in our midst are the ones that need to feel safe and comfortable that those services are actually providing services that are appropriate. I think minimum interpreter services, obviously, having been used as an interpreter as a child I don't recommend that, and I would hope it doesn't happen but I know it does so interpreter services are in minimum but language is more than words.

Language is about many explanatory models of illness, and I know Harvey understands this very well, but the whole idea of working with explanatory of models of illness and actually start understanding that is really important but I do think it comes down to the culture of the system. We don't have a compassionate system. People talk to us about the lack of compassion and kindness in the system; that's not because we don't have good staff. That's because the system is at breaking point and I think that unless we can actually change the culture in which we're operating as a society and as a - not just mental health, health system, because mental and physical health are closely interrelated, nothing's going to change. So with (indistinct) communities, a term that I don't particularly like, but with, you know, - - -

MS ABRAMSON: I'm just using that as a - - -

MS PIU: No, no, I understand. But with multicultural communities I do believe that it isn't a matter of necessarily having a cook book and looking up what we do with one community and another community, I think that's often been the approach that people have taken. I think we have some basics in place and we have basic compassion and we understand and we ask how best to connect then we're going to get somewhere otherwise people are not going to come forward, they're not going to speak, they're not going to feel safe.

PROF WHITEFORD: I think - yes, (indistinct words). So the issue is, coming back to what Julie and Stephen asked, what can we say - what can we recommend concretely that should be different? If it's about, 'Let's just all be, you know, less, you know, discriminatory in how we deal with people with mental illness and their families'; so how do operationalise that? If we go to the chapters that make the recommendations around carers, we recommend reduce the barriers for access and income support, deal with the employment support issue, deal with family focused and care inclusive practising services and we've got things in there that we say we're going to do; what's missing?

So I'm not asking you to answer us now but if you could come back to us and say, 'Well, look, we think you, you know, you've said the right words', if we have, 'but we think the recommendation which should be in there which isn't in there' or 'the recommendation you got falls short because of this', then that would really be helpful because it's people who are close to the coalface of these services who can perhaps have more precision than we might have in the Commission.

MS PIU: I'm happy to do that. I think the main thing, and I'm sure the others from Mental Health Carers Australia would talk about, is the practice standards that are provided, for instance, the practical guide for working with carers and families but again unless you do that within a different culture of work, a different work culture, unless we shift the culture it won't be sustainable and I think it's a problem that we have around the country.

PROF WHITEFORD: Yes.

PROF KING: Just following up from Harvey. Also when, this is an old term, but the (indistinct) communities when thinking about recommendations for them. Yes, in some ways we've been quite high level in saying, 'Well, we don't want to specify what services are appropriate for this particular region which has - I live near Box Hill which is a very large Chinese community, the services that would be appropriate for that community are completely different to say North Brunswick/Coburg where it's an Islamic community, for example, because there are significant cultural differences in the appropriate to mental health under, you know, a whole range of issues.

So we've in a sense said, 'Well, that's up to regional commissioning bodies to work out what is best for the communities where they are serving'. But we being then - a number of people have said, 'Well, you haven't come up with recommendations for the (indistinct) community' and I guess I sit there and say, 'Well, we have. We've just tried to make it flexible enough to deal with all ranges of cultures and issues' so if there's something practical that we've missed I really would like, you know, if you could put your mind to what/how that should be phrased then I would really be very pleased?

MS PIU: I think codesign and coproduction it's what missing from there and so if I think about it, you know, again it's 'doing for'. I think we've moved beyond 'doing for' anybody (indistinct words) and I think there are members of all communities, whether they be Aboriginal, whether they be multicultural, who don't want to deal with culture specific services and they might want to come to a mainstream service for a whole lot of reasons and they need to feel safe to do that so we need to think about what that means.

PROF WHITEFORD: How the mainstream service can be safe, yes.

MS PIU: That's right, absolutely, so I think that - but I think codesign and coproduction again in the papers that we've developed in Victoria it's very, very clear how to do that and I think that we're trying to do that here and I think we can do it but it's about asking, 'What would you like?' so in Brunswick what does the community want? And the community is quite diverse in Brunswick so I think it would be a very interesting picture.

PROF KING: Thank you very much.

MS PIU: Thank you.

PROF WHITEFORD: Thanks, Marie.

PROF KING: Next we have Professor David Copolov and Professor Tarun - - -

PROF BASTIAMPILLAI: Bastiampillai.

PROF KING: Bastiampillai.

PROF BASTIAMPILLAI: Yes.

PROF KING: I have to ask, so it is Sri Lankan or South Indian?

PROF BASTIAMPILLAI: Sri Lankan.

PROF KING: And if you could state your name and who you're representing for the transcript and then if you could please make any opening comments you'd like.

PROF COPOLOV: Okay. I'm David Copolov, Pro Vice-Chancellor of Major Campuses and Student Engagement at Monash and Professor of Psychiatry at Monash and at the University of Melbourne but I'm not representing my university in regard to this consortium. Tarun and I are speaking on behalf of a consortium of psychiatrists and a psychologist, that's Associate Professors Stephen Allison, Geoffrey Waghorn and Professors Assen Jablensky, Vaughan Carr, David Castle and Bruce Singh. So we're sort of a chorus of individual opinions in psychiatry and psychology. Would you like me to make some opening submission and then for Tarun to speak?

PROF KING: Yes, Tarun, if you're just able to state your name for the record because need to be able to tell different voices apart.

PROF BASTIAMPILLAI: Tarun Bastiampillai, Professor of Psychiatry at Flinders University.

PROF KING: Thank you.

PROF COPOLOV: Okay, so first of all we would like to say that this is a most impressive draft report and covers a huge range of areas and we would, in our submission, which we'll be

providing 23 January will be providing comments on many of the sections. We are going to focus on sections 2 and 5 today and in the supplementary material that we provided which included the recent report from the Treatment Advocacy Center in the United States on the huge problem of boarding psychiatric patients in emergency departments in that country, the report commissioned by the United Kingdom on the need for at least 1000 additional beds in the United Kingdom and that's a country that has 90 number of beds than we do and also the impressive article from our group in the issue of Western Australia and the problems that have been associated with mental health services in that State as highlighted in the Western Australian Auditor General's report.

Since then the Journal of the West Australian AMA has highlighted that in the month of September 228 mental health attendees spent more than 24 hours in West Australian emergency departments with an average of 38.5 hours with more than 8800 hours being spent in the emergency department in that State in just one month. So we wish to address only a few of the areas because of time constraints. The first one is that although your recommendation 7.1 says that it is really up to the States and Territories to determine the level of service provision within the regions within their State and Territories and to undertake to provide those services.

It's our view that the general tone of the report is essentially that if you can avoid inpatient care that's a good thing to avoid and this is actually in keeping with the Australian overall philosophy towards inpatient care and I really want to emphasise that when we talk about beds we're not talking about pieces of hospital furniture, we're talking about the care; the high level professional care that comes with inpatient care. When Australia dropped its number of psychiatric beds from 30,000 in 1965 to 5000 in 2005 at a time when the population increased by 80 per cent there were many advantages to that reduction because of the fact that there were some poor practices in the larger institutions but this is a definite example of overshoot of reduction in beds and it's contributing very substantially to these high stress levels felt by consumers, patients, family members, staff.

The crisis that is very common within emergency departments, and although there's mention in your draft report of alternatives to emergency care, one of the alternatives that isn't given sufficient attention in our view is the need for more beds, both acute and non-acute. There is an emphasis in Chapter 7 on those beds being provided in community settings. In our view more beds should be provided as non-acute hospital beds.

The second that we'd like to address is something that didn't get into the draft report and that is the idea that there should in fact be the establishment of specialist mental health centres which are university affiliated in co-located general hospitals. As a Productivity Commission clearly your interest in issue such as economies of scale and yet in psychiatry mental health generally there has not been sufficient attention places on economies of scale that come with things such as hospitals and specialist aggregation of expertise.

If I could just say that I've spent 14 years as a director of public specialist hospitals in Victoria, nine years as director of Peter MacCallum, six as the deputy chair of Peter MacCallum Cancer Institute and five on the board as a director of the Royal Women's Hospital. The quality of care that's provided by specialist public hospitals in ONG and neonatal care and in cancer is just not provided in psychiatry. When I was on the board of

Peter Mac we were working towards and eventually there was a $1b building for Peter Mac and there are 580 researchers there, there is a wonderful (indistinct words), there are huge numbers of clinical trials, we don't have that expertise and what's more we don't have the philanthropy. Peter Mac raises nearly $50m a year in philanthropy. You don't get a lot of people donating a lot of money to mental health wards in general hospitals.

And finally, I'd just like to say in relation to your very important section on governance pulling the reforms together. Draft report recommendations 22(1), 22(2) and 22(4), the role of COAG, the possibly expanded role of the National Mental Health Commission, the creation of regional commissioning authorities; all of this is very important and the idea of introducing a national mental health and suicide prevention agreement and a new hull of government national mental health strategy is very important.

But it's interesting, a lot of what is happening both with the National Mental Health Service Planning Framework and the like are expectations, goals and aspirations and we actually think there should be more in the terms of requirements and one of the things in my recent visit to Germany, the German federal government has introduced a new law which sets minimum standards of the amount of time that is allocated per particular mental health professional per patient per week, this has actually been an ordinance since 1990 and is being introduced as a law is to begin 1 January so these are requirements rather than aspirations and we think there should be more requirements in terms of minimum service provision in whatever configuration of agreements and strategies are developed as part of the implementation of the Productivity Commissioner's recommendations. So I'll leave it to Tarun.

PROF BASTIAMPILLAI: Thanks for the opportunity to speak today. I'll be focusing on the bed numbers and the requirements from a modelling perspective. My context is I was a clinical director in a local service in Adelaide which is confronted by EDQ issues and supply demand mismatch so it's sort of interested in the bed numbers and the community resources that are required to address that kind of complex problem and then for the last years three in (indistinct words) for mental health services in South Australia asked to look at that problem at a State wide level and look at how many beds and (indistinct words) with interest Professor Harvey Whiteford's National Mental Health Planning Framework and (indistinct words) meetings around the modelling.

I guess at one level I looked at the OECD (indistinct) and we looked at the countries. Anglo-Saxon countries tend to be low, European countries tend to be high, the average is 71 so I was just interested in that number as a starting point, a normative kind of modelling. Australia sits at 42 of which 13 beds are private sector and there's a been a growth in private sector and the public sector's effectively been static at about 29 beds (indistinct) 1000 so I was interested in that as kind of almost like a social cultural phenomena, Anglo-Saxon versus European.

And my personal experience working (indistinct words) it was roughly 60/70 beds I never went to the ED, there was no queuing problem, we had good social services, I could admit directly to the ward and there wasn't so much residential facilities but I could easily admit to a ward so it was quite puzzled by what I was seeing in Australia but it was clearly from my point of view a supply demand mismatch. And the World Health Organisation has high

income countries sitting at about 50 and European Union sitting at about 50 so these are kind of what I would think as comparative benchmarks.

So the question is within Australia sitting at 29 beds (indistinct) is it right and can community investment prevent the need to increase acute beds or in fact decrease acute beds. From my point of view it's sort of like a tipping point. I think Australia's tried to reduce acute beds for the last 10/15 years and has been unable to do and there has been increases in community investment and I note with interest your graph which showed the community investment growing up until the last five years where it's static but (indistinct words) primary care stepped in and big resources have gone into psychiatric depression but if you look at the codes that are coming to our ED departments they are crisis patients with anxiety, depression, drug and alcohol so when I look at the ATAPS and Better Access program which is meant to treat anxiety-depression I'm puzzled by the numbers coming to ED with anxiety and depression so more of ATAPS and more of Better Access I'm not convinced will register a signal in the ED and therefore when I'm on the frontline with 20 people in the ED with anxiety-depression what is the solution in the short term (indistinct words) long term.

So in terms of our consortium we put together a kind of framework bearing in mind national mental health (indistinct words) has quite sophisticated algorithms that drive it. Our numbers for general adult, and I think in your document a helpful sub-analysis (indistinct words) because the quantums are different and the needs are slightly different so on general adult the national average is 24.5 acute beds, our proposal suggested 30. For non-acute beds the national average is 9.5, we suggested 15 - effectively a 25 per cent increase. And with residential beds the current Australian average is 10 and we suggested 20 so our net was about 65 and the current average is 44.

Now, I guess there's a semantic issue about non-acute beds, we're in agreement about the need for non-acute but the question is should that be in a community residential facility or a non-acute inpatient ward and I think that that's an ideological question, a practical question, a policy question and there's concerns about what a non-acute bed represents from historical terms but again about the scale, the economies of scale, there's some advantage in having rehab precincts where you get core location of expertise.

So I think our modelling, we're not convinced that community residential can substitute for the acute and non-acute to the extent that's inferred in the Productivity Commission documents. That's probably our only major point of difference about residential. I've had practical experience of running residential and the kind of patients that can go to residential facilities are quite different than what we see in acute and non-acute and to be honest it's psychosis with intellectual impairment with drug and alcohol issues and with potential progression and when you've got a small 20 bed unit in the community the occupational health and safety issues present a problem in terms of realistically managing this in a community setting. So, thank you.

PROF KING: Okay. I suspect Harvey's going to want to first question, so.

PROF WHITEFORD: Right. So I think if you look at the recommendations in the draft report where the modelling to date, and this is a draft report, was a small increase in acute beds and large increase - and 80 something particular increase in some acute/non-acute beds

and we can debate where those beds should be but I think why are we recommending a higher increase in acute beds I guess is the biggest issue and there's two issues for consideration there from I think the Commission's point of view, the first is that the submissions we've had and the people we've spoken to, when we've gone to acute units and we've asked, 'Do you need more beds?', the answer is, 'Yes, we need more acute beds' and then we ask, 'Well, of the people who are in your ward now', and you've heard this many times, 'who don't need to be here or could be discharged or wouldn't have needed to be admitted, how many?' and the answer to that is somewhere between 20 and 35 per cent. So the pressure then is to try and address that and, you know, allow people not to be admitted because there's alternatives in the community or there is, you know, options that allow earlier discharge.

Now, the length of stay in those units is shrunk and shrunk so I certainly agree that the length of stay now is very short I think clinically so I'm not sure that shrinking it further is necessarily going to be that therapeutic and that the length of treatment in those units is maybe better provided of what the patients need in non-acute beds or longer term inpatient care. So it's about that balance. What you're saying, Tarun and David, and correct me if I'm wrong, is that there may be some evidence that the provision of those community alternatives, although as you point out it's plateaued and in some places like Victoria it's gone down, hasn't taken the pressure of the acute beds or the need for acute beds and I guess that would be something we would like to see (indistinct words) and to consider for the final report.

PROF COPOLOV: So in your report you've highlighted the fact that it seems to be a paradox but it's not, that there's both premature discharge and delayed discharge. The delayed discharge is because there aren't sufficient non-acute beds and (indistinct words) suitable, the premature discharge is that we are discharging the least unwell not people who have fully recovered. Now, it's our view that when you have a system as we have in Victoria where it's mainly risk management and only admitting people where the threshold to be admitted is that you have to be a danger to yourself or a danger to other people is such an incredibly inappropriate threshold. It is totally inappropriate.

This is where we want people to understand that there is a value in inpatient care. Only a small proportion of people need inpatient care but when hospitals, I'm a great proponent of hospitals when they're needed. If you've got sepsis, if you've got spinal trauma, if you've got a myocardial infarction, hospitals are good places. If you've got a severe psychosis where you are out of control and you're a danger to yourself or even if you've got severe depression and you're not suicidal but you've got terribly treatment resistant depression and you don't happen to have private health insurance you should be able to go into a hospital.

I've just come back from Germany where the compulsory admission rate of the patients who are admitted is closer to 6 per cent rather than 55 per cent in Victoria so we have first of all to reduce the bed occupancy rate from 95 per cent to 85 particular, which is a recommendation, to reduce the threshold so that you don't have to be a danger to yourself or others to get into hospital and so you can have lengths of stay where you can actually recover. All of these things require, in addition to non-acute beds, require increased acute beds.

PROF BASTIAMPILLAI: I'd agree. Just one added point. The logistics of (indistinct words) governance, I think that some acute sectors are not linked with the acute in community sectors so there's kind of inefficiencies, it's a logistics problem going from community to ED to sub-acute and you're seeing four psychiatrists where in England where I worked I managed everything. I was almost like a village psychiatrist, I knew the 20 GPs, the GPs would give me a call, I'd say, 'I'll see the patient tomorrow', I'd admit to the residential facility and/or the inpatient facility but that was England.

London is a village and I operate as a village psychiatrist but here it's suburbia and I operate in a silo so I think one of our problems is not the resources but how to integrate resources and how do we have governance at the very local level. I saw your statements about governance at the top level which I sort of agree with, a complex problem, but how do you replicate the English model where I can chat with the English GP and organise an appointment within a minute without an incentive structure and I was on a salary.

PROF WHITEFORD: Sorry, can I just follow up on exactly that point because (indistinct words) a question that I wanted to ask which is the interactions between the beds that - you know, it should be a smooth flow of the patients/consumers between the different settings (indistinct words) settings. So it would be good to get more details exactly about how it works under the NHS, which I assume is - - -

PROF BASTIAMPILLAI: Yes.

PROF WHITEFORD: And our approach through the Regional Commissioning Authorities in a sense was an attempt to look at a body that was able to bring in that sort of coordination so you may still have in a sense a hospital with a silo but it's the commissioning authorities' job to be making sure that the lengths of (indistinct words) acute/non-acute community beds so that you don't - you know, you had that linkage up with the services. Your thought on that, your thoughts on what different that sort of linkage would made then to the sort of analysis you on had beds?

v COPOLOV: So, in our - sorry, do you want to - - -

PROF BASTIAMPILLAI: (Indistinct words) talking I believe in linked datasets so if you have an acute/non-acute GP that first step is the linkage to the datasets, that's the first utopian position, or dystopia in some
people's - - -

PROF KING: (Indistinct words) viewed that as, you know, why we can't do
this - - -

PROF BASTIAMPILLAI: Yes, so that would be the starting point, that's a Scandinavian kind of idea. The second step is that I as a psychiatrist in an ideal world will look at a consumer in a holistic fashion no matter where they are and that the governance and the organisation between me and the GP's link and that customer is both the patient and the GP so I need to have 20 GPs in my patch and I service the training needs, the (indistinct) of the GP and then that a seamless integration on the one care plan which is under governance of a psychiatrist and an MDT team working holistically for the patch.

However you define the patch; Coburg, Brunswick, Box Hill and the Box Hill might be more Chinese and Coburg might be more Islamic et cetera so then you'd liaise with the right sociological infrastructure with a linked dataset. Now, that is possible in NHS and the governance of the NHS is integrated and the structure of the NHS is integrated at that local level. I think Australia will struggle to do that; hence we've got mental health commissions, state bodies, chief psychiatrists, planners, national mental health plans, universities. It was very, very simple in the English model and to some extent I'd love it if we could replicate that local planning.

PROF COPOLOV: So a larger consortium of us put in a submission that you received called the Adults Psychiatry Imperative, and within that submission is a detailed section of what we've called mental health integrated service hubs, which are based on the integrated (indistinct) which are in Victoria, which includes the components that you so rightly emphasise in your report about navigating. It's so complex for people to navigate the various opportunities to be involved, not only in the medical services sector but also housing and legal advice and the like, so we were recommending that there should be an integrated hub which maps to what we're calling mental health networks which are similar in geographical areas to the PHNs that could enable people to be linked via hospital to GPs, to private psychiatrists, and in your report you've highlighted that the private sector really needs to be brought into this whole issue in a major way, so the need for integration is something that we consider very important, and then the question is, as you addressed in your report, who at what level should be the commissioning agency should the integration be responsible for because we do have the Commonwealth and state having different responsibilities.

MS ABRAMSON: I had a very general question. Mr Copolov you made a really interesting - you made a lot of interesting comments, but you made a really interesting comment about how the resources aren't in mental health or the philanthropy in the way they are when you were at Peter Mac, so what can we do to change the community discussion around this so that we say that people are asking for, one, that type of service that you're talking about and we can get the type of models that we have, for example, at Peter Mac with cancer care?

PROF COPOLOV: So it has a lot to do with the destigmatisation that you've addressed in your report, but it also - having raised a lot of funds both for the mental health research institute when I was director for 19 years, and also subsequently for I've been on the foundation board of Peter MacCallum. These are highly professional organisations. They require extremely dedicated people. They require data sets and networks and I think - and organisations, and this is why I'm saying, for example, if we had a Peter MacCallum or two or three Peter MacCallum equivalents in each city and we had some rehabilitation centres as well, we could attract the staff who would then focus on the highly professional task of raising funds.

So there are organisations in Australia like Mental Health Australian, Beyond Blue, Orygen. They raise funds, but you need a significant size of organisation and you need a dedicated fundraising team.

MS ABRAMSON: To get back to your point, though, how do we get there from where we are now? Like, what sort of recommendations would you have for us?

PROF COPOLOV: Well, I just go back to my point that there is an anti-aggregation - it's very interesting talking to the Productivity Commission about lack of economies of scale, but we don't have - we have a sort of a - what happened when the institutions and old hospitals were closed is it was very good. They had economies of scale but there were some very poor things about them. But now we've gone the other direction where you've got it distributed to too many different sections, so you don't have centres of excellence, so I think that's an important element.

PROF WHITEFORD: I'm just going to squeeze this in before we finish.

MS ABRAMSON: I see your beady eye.

PROF WHITEFORD: Yes, well, we could go for a long time. We probably should, but can I jump to the point you made about the minimum standards of care for time allocation from the German work you've seen. I've read your submission. The references are in German and I assume that could be written in German, so it would be good to get them in English. But one of the things we have identified in the report, which is of significant concern, is the efficiency of the community mental health service. This is the public sector community mental health service. There's an activity-based funding which often drives the inpatient services, which has its own problems, but at least it's there. In the community services as they currently exist in the states and territories, they're largely block funded, and the data we've got suggests that there's nothing in the funding of those services that drive efficiency or increase productivity and that the time spent by FTE equivalent clinicians in those services is often much, much lower than we would like and certainly much lower than, for example, is in the national service planning framework. Anything that you could show us or suggest from the German experience that you've mentioned in your documentation or other information you might have about how other governments tackle that would be gratefully received.

PROF COPOLOV: Okay, so it's very important because in your draft report you highlighted that face to face contact of community health service is only about 30 per cent, so there could be a significant improvement by reducing administrative burden on community mental health workers, I think, as well as increasing community mental health and the like. That's why in the new Psych VVG there is a - - -

PROF WHITEFORD: Sorry, that is the - - -

PROF COPOLOV: That's the new law, sorry, for – - -

PROF WHITEFORD: In Germany?

PROF COPOLOV: In Germany, coming in on 1 January. There are requirements for quality as well as time, so you're right. It's just spending time may not be sufficient. So we'd be very happy to provide that.

PROF WHITEFORD: That would be very good to see. Thank you.

PROF BASTIAMPILLAI: Harvey, I'd just like to respond to that. Having run and managed community mental health centres, I was puzzled by the lack of face to face time. If I was a GP or in private psychiatry it would almost be a bankrupt business. If you converted that all into fee for service, it wouldn't meet the fee for service test, so I always thought about whether fee for service would work in community mental health, and then the other point is gaining or seeing people that may be less complex, and you traversed that in the document.

But I think community mental health is not actually aware that their times are that low so I think benchmarking and that we should benchmark, say, North Sydney face to face time 50 per cent, Flinders Medical Centre face to face time 10 per cent, and that already starts to put me on notice as Flinders Medical Centre, so I think that's an important point about benchmarking which is covered. We need to make that clear to community mental health, that there is a standard, whatever that standard may be. I think it's realistically 50 per cent, is my view, but the administrative burden and the logistics and risk management may be community mental health but almost become like an insurance industry, checking on risk, but checking on risk versus addressing risk are two separate things.

I think community mental health is very scared about suicide, and in that context there's over-emphasis on risk management, and that has lessened the effectiveness and efficiency of community health.

PROF WHITEFORD: What you're implying there is that risk management results in more perhaps bureaucratic documentation to try and cover activities which takes away from time that clinicians might spend with consumers.

PROF BASTIAMPILLAI: Yes, yes, I think so, and I think that the data and the linking of the data would also help community mental health, and attaching ED avoidance to community mental health matrix, so if you're in the region in the community I would say your ED rates of anxiety disorders are - compare to the benchmark, so I'd attach hospital KPIs to the community. At the moment they've been disconnected. So if I'm going to set up an anxiety disorder service in the community, I would set some efficiency benchmarks and I would also say, 'Did you reduce panic disorder presentations to the Royal Adelaide Hospital?'

PROF KING: Thank you very much. Thank you. Next, we have Andrew Marks. If you're just able to state your name, affiliation for the transcript, and then if you'd like to make an opening statement.

MR MARKS: Sure. Good afternoon. My name is Andrew Marks and I'm the director of counselling and mental health programs at Monash University and my very good colleague, Professor Copolov, asked me if I could put together a response to your draft recommendations on behalf of the university, so to some extent that's what I've done, although I'm sure I've missed bits and pieces here and there.

So I really appreciate the opportunity. I'm not sure if you've had any presentations from other universities, but I've been at Monash for 27 years and I've seen a tremendous change in the sorts of presentations that we have seen in through the counselling service from when I started, and I suppose there is a fundamental question of why do universities have

counselling services, and I know at Monash they first established theirs in the late 60s I think.

My view about that is that our role is to support students in attaining academic success, and so when I started back in 1992, a lot of the sorts of presentations I was seeing were, 'I'm not sure if I'm in the right course,' you know, 'I've just broken up with my girlfriend,' relationship issues like that, and they're of course still a lot of what we do see coming in, but what I've noticed, particularly in the last 10 years is a significant increase in the severity of presentations, both in our local population and our international student population, to such an extent that during teaching semester time we'd be needing to get a student to hospital by ambulance probably once a fortnight, so that's the really pointy end of the work we do.

Just to give you some statistics maybe to talk about that first, so this is from Monash's 2018 publicly available statistics, we have 72,600 odd students on our Australian campuses, so my role just covers the Australian campuses. We saw some 6,018 students came in to use our services, which is 8.3 per cent of the total student enrolments. One of the points you make in your draft recommendations around full-time equivalent ratio of counselling staff to student population. It's great to have a look at that, actually, because I hadn't looked at it for a couple of years and Monash is now at 1:2,500, a little bit - so that's quite remarkable because last time I looked at that we were about 1:4,000.

We've had a significant restructure - two restructures really - in the last seven years, which has enabled us to bring that ratio down and I think increase our overall productivity and capacity to meet the ever-increasing demand of students wanting our services.

So I just want to explain what we've done. The traditional way of engaging psychologists at university counselling services is as employees. We were just finding that we weren't able to meet the demand and so about six, seven years ago we introduced workforce to sit side by side our employed staff of private psychologists working under Better Outcomes using Medicare, so obviously they need a referral from a GP, but we've got a comprehensive health service, so our GPs can write those referrals and we're all co-located in the one building. So that, without any real cost other than providing a room, increased our capacity quite dramatically.

Probably three years ago we introduced a third model, which was not using Medicare but engaging a workforce of psychologists working privately still for themselves but contracted to provide those services to the university and then the university pays them directly.

The advantage of those two additions to our workforce is that those two groups, the Medicare and contractors, just do clinical face to face work, and what we pay the contractors per hour of consultation is exactly the same as the Medicare item number for that service that's paid by Medicare to the Medicare psychologist, so there's no differentiation and there's no cost to the students. It's a free service.

And it's a free service also - one of your questions in the recommendations was around health insurance for international students, so I just want to talk a moment about that. There's a number of companies that provide health insurance to students studying from overseas. I understand it's a requirement of their international student visa that they have that insurance now. There was a time when it wasn't, which was really problematic for very ill students, but

we've moved past that.

For Monash's situation, our preferred supplier is Allianz but the student is free to take up whatever company they'd like to. The reason I mention Allianz is because for students that have chosen them, when they come into our health service they don't have to pay an upfront fee because we've got an arrangement where we can just bill Allianz directly for the GP consult or the psychologist consult, so all the time we're trying to lower the barriers to access of our services.

For students with other health funds, they have to pay but they'll get 100 per cent refund for that. It's my understanding that the health insurance providers mirror the Medicare item numbers and the dollar amounts attached to those, so that if we're bulk billing the students aren't out of pocket and that's really important.

Where we do have a problem for international students, or where they have a problem, is if they are needing to attend emergency departments. What we've found in the last few years is - and I think it's now universal in public hospitals - emergency departments are charging an upfront fee when an international student presents to the concierge, and that can be in the range of $600, and sometimes that's prohibitive. So we might have a student that needs to go to hospital, we might have spoken to psychiatric triage and they recommend that they get the student down there and then they're confronted with this upfront fee.

Again, for our students, we have Monash Medical Centre and the Alfred which are the two major hospitals closest to where we are, our major campuses. The concierge can ring up the health fund and they'll pay for that over the phone, so again, the student is not out of pocket.

But as a general principle, that's a significant problem, I think, for these students that are disadvantaged anyway and that is an enormous amount of money for them to try and find to pay upfront.

Just on our international students, I think there's a general perception that - so a lot of our students come from Asian cultures. There's a lack of willingness to engage in mental health services. What we've found is at our Clayton campus - this is based on last year's figures - 30 per cent of our enrolments at our Clayton campus were international students but 33 per cent of our patients coming through into the counselling service were international students, so they're slightly overrepresented, so it kind of goes against that general perception that they're reluctant to access mental health services.

At our Caulfield campus we've got 62 per cent of our enrolled students at that campus are international and they comprise 50 per cent, so they're a little underrepresented at that campus, but they still make a significant proportion of the students that we see. Unfortunately, they often come later rather than earlier and often they're sent by academic staff and so unfortunately if they'd sought treatment earlier they may not have got themselves into such a dire situation.

So it's interesting with that model. We've got three different types of engagements. At the moment, we've got 29 FTE of psychologists working in the service, 10 are employed staff, seven are Medicare under license and 12 are contracted.

I just wanted to mention one thing to keep in mind regarding the ratio. There's a lot of talk about the ratio of counsellors to population. The ratio is important to look at but it's also really important to look at what are those staff doing between the time they come to work and go, because one of the ways we've been able to increase our capacity is by having these dedicated staff that are just doing clinical work, and they're for the most part not full time, so they're maybe seeing six, seven students a day, whereas our employed staff actually are running a lot of our mental health programs and so when they're not they're probably only seeing five staff a day, so in terms of efficiency, we found this model to be enormously beneficial to just meeting that constant demand for walk in and phone call appointments.

I feel like I'm going on. I've got a few more things to say, but – - -

MS ABRAMSON: No, no, it's been great. Thank you.

MR MARKS: I'm welcoming of any questions. I've got a little bit to say on some of your recommendations around staff training, so do you want to – - -

PROF KING: I was going to ask you a question about that.

MR MARKS: Yes.

PROF KING: So thank you. At the moment, lecturer As, for example, who have quite close contact with the students would receive training in general on teaching methods and so on, but as far as I'm aware no specific training on the mental health of students, how to recognise students that may be under stress. Going through from there through to, say, PhD supervisors. I know Monash has a PhD supervision requirement, training, although many academics are grandfathered from that. Again, I'm not sure if that has any issues relating to either recognising mental stress or students or issues of bullying or potential bullying so that the supervisors can be aware of their own conduct.

So I'd be very interested to hear what your views are on the needs or otherwise to increase mental health awareness, mental health training right through that workforce from literally the lecturer As through to the level Es and the post-graduate supervisors and so on.

MR MARKS: Sure. How long have we got? I provided the Commission prior to today with a copy of our mental health strategy, so Monash developed that back in around 2012, 2013, and I think it's on p.4 there's a pyramid which sort of graphically shows the different levels of that strategy. The third level is mental health literacy and that's where this training comes in. So there's a very significant need for training academic staff and professional staff as well in recognising the presentations of mental stress, mental health problems, and knowing - not just recognising, knowing how to interact with the student and then knowing what their limitations are and how to help that student get the support they need, and there's two maybe obvious reasons for that. One is for the student's wellbeing and one is for the staff's wellbeing.

So we run a range of mental health literacy programs for staff in the university and have done for many years. There's a 12-hour program Mental Health First Aid which I think you

mention in your recommendations, and we've initially started back in 2007 running that for staff, and I think in 2005 or 6 there was a Senate Select Committee report which briefly talked about Mental Health First Aid and recommended that 6 per cent of the workforce, particularly with roles where they're interactive with the public, undertake that training, so we thought, 'Well, we'll adopt that at Monash.'

We charge staff for that, and we've recently - or not that recently; probably about six years ago - made it available for students and about four years ago made it free for students, and now we train far more students than we do staff. So the point of that, that rationale for that is that peer to peer support is crucial in getting early connection with mental health professionals if that's necessary.

PROF KING: Just on that, are the actual staff interacting directly with the students on a day to day basis, and I'm thinking of the educational staff. Six per cent sounds a very low number to me. I mean, I would have preferred a number like 100 per cent.

MR MARKS: That was back in 2007. We have moved on - - -

PROF KING: Is there compulsory - I'm not sure across every faculty, but certainly a faculty that I know quite well, no tutor ever got in front of a class until they had had basic training, and there was I think a two-day workshop that they all had to do on teaching methods, interacting with the students. Now, from memory there was no mental health training in that. The real question is, should there be?

MR MARKS: Yes.

PROF KING: Okay.

MR MARKS: Yes, there should be, and one of the problems we've had is that a lot of those tutors, especially at the undergraduate level, are often post-graduate PhD students, they're employed as casuals and so faculties have been reluctant to pay the hourly rate for non-core training, so we did a - we got some money about eight or 10 years ago and focused it on those tutors because they're often the first point of contact that undergraduate students have with academic staff where there's an emerging mental health problem, and it's usually when they're asking for an extension and the tutor might say, 'So why do you need an extension?' Now, that question can often open up everything. 'Well, you know, this is -' so we wanted those frontline tutors to be trained in the mental health literacy and knowing what the services are that are around at the university and how to help facilitate those referrals to professional help.

We found that the 12-hour program was a bit of a barrier because it's a long program, so we've had requests across the years and we've created a cut-down three-hour version that we run for those tutors now and we still want staff to do the 12-hour program but the answer to your question, yes, I think it would be compulsory for tutors. Now, I'm not big on compulsion, but increasingly it's seen as relevant necessary training for academic staff to do their job. It's not an onerous amount of training. You know, three hours is not really asking too much, and I think if staff are viewing that as a way of helping them to do their job, there's probably going to be a good uptake.

PROF KING: I'll look to my colleagues because they know I could go on about this all day.

MS ABRAMSON: No, I'm happy to allow you to, Stephen. You may not be able to answer this, Mr Marks, but when we had some of our earlier consultations students said to us, 'Well, it's all very well that you're talking about support for mental health, but actually the academic side of things was not flexible so I needed to drop out of university because I couldn't actually get a leave of absence for mental illness,' or 'I couldn't come back on a part-time or sessional basis.' I'm just wondering - you talked about mental health literacy for the staff - how you're making - and I am an ex-graduate of Monash - how you're making the clunky university processes responsive.

MR MARKS: One of the areas is special consideration. That's really what you're talking about.

MS ABRAMSON: Yes.

MR MARKS: So I sit on - there's a university-wide special consideration committee which is quite bureaucratic but they're doing their best. I sit on that committee and advise them.

It's an issue of bureaucracy to - one of the things with this updated strategy that I sent you, and we updated it in 2018, was to make it a whole of university strategy. Prior to that, we called it a whole of university strategy but it was really the counselling service strategy, and so one of the things we did was spell out in this new updated strategy what's the responsibility of the health and counselling services and what's the responsibility of the whole university? So I would see the special consideration bureaucracy, just to take one area, is where the whole of the university needs to step up and consider the mental health implications of decision that they're making.

Not particularly do anything differently unless they can see that they're making a decision where an unintended consequence is to damage the mental, health of their students, and an example of that was - which we were able to change quite easily, was the university used to release semester results on a Friday afternoon. There's no services that we can provide that are available over the weekend and I pointed that - and it's actually quite a risk for students that are vulnerable, and so we were able to have that discussion with examinations and they're now released on a Monday morning, Sunday night if you've registered for SMS. But that's just one example of where we try and work when, from my point of view, I can see an issue which would be relatively easily fixed.

But you're absolutely right. I mean, the students that gave you that feedback are correct in saying that often the bureaucracy can get in the way of having good outcomes when it's not necessary for the bureaucracy - you know, the university doesn't lose anything by being more flexible. It's just often they're unaware of it.

So my answer to that, it's about cultural change, it's about increasing awareness of the people in the faculties and elsewhere who are making these decisions and these policies just to consider the potential mental - just ask the question, 'What are the potential mental health consequences of this decision?'

Another one is where progression is affected to the point where students are unable to - are no longer eligible for Centrelink, because financial stress is a huge component of emerging mental illness. It's not on its own usually but it's a component. So that's what I could say really in response to that.

MS ABRAMSON: That's really helpful. Thank you.

PROF WHITEFORD: I'll ask another one. You mentioned the counselling services when you started were, you know, really services for academic success and that the severity - the issues have changed over time. One of the questions we've asked of all institutions for the workplace, for schools, tertiary institutions, is really if there is a functioning and a well-operating in-community mental health services, do they need to be replicated? For example, we suggest wellbeing leaders in schools that can act as links in the community, not psychologists in schools. We've got similar linkages in the workplace. Universities seem to be slightly an oddity in that as you've said you have your own counselling services, some of which look like community services. You mentioned the Better Access program, but at the same time you also have psychologists on a contract basis.

So I'd like to get your views about whether a better way - if you were starting with a blank sheet of paper, would you go to the situation that you have now at Monash or would an alternative, and I'd be interested to know if you'd view it as a better or worse alternative, be that Monash would be an effective gateway into non-Monash community-based services. Just your views on that and which way we should be thinking about in terms of our recommendations.

MR MARKS: So I wouldn't - I think the model of having on-campus services is really important for access. Not just convenience, but - in fact not particularly convenience. If you imagine yourself as an 18-, 19-, 20-year-old with emerging anxiety or depression and you've never accessed any professional help before and you begin to feel like you're not coping too well, it can be quite frightening, just within yourself. You think, 'What's going on with me?'. So to try and facilitate access as easily as possible and lower the bar as much as possible, I think the on-campus services are essential, and often students will come in minimising why they're coming in and it will be - they'll say something like, 'I want some tips on time management.' But by 40 minutes into the session it emerges that there's some really quite profound underlying anxiety or depression or both.

So it's not so much stigma, it's fear, I think, that's the barrier. That's one thing. It maybe answers part of your question. The second question is our linkage with external agencies, and that's, again, one of the tiers in that pyramid in our mental health strategies, and where - universities exist within a larger community, obviously, and we're not trying to replicate. In fact, we rely on the external mental health services and hospitals that are available, particularly as we're seeing this increase in severity. Like acute presentations, but even chronic presentations that are beyond the capacity of our service to see, they may need, you know, weekly appointments. We do have a psychiatrist who bulk bills but he's just closed his books for the rest of this year because he's overwhelmed and he's not full time.

So we need to have access to those external - it's a collaborative relationship that we have with the external services. If anything, what we find is - and I'm sure you've heard this a lot

and I know you've written about it in your draft report - is the difficulty of getting acute illness treated effectively in the public system. So what we find is we may get a student that site triage says, like I said earlier, 'Get them in a taxi, get them down to ED.' But they'll be seen by a registrar, usually not admitted and sent home again knowing in their minds that they've got access to a fully functioning tertiary health service, and these are often quite acutely suicidal students.

If they're presenting with - there seems to be much more willingness to admit a psychotic presentation than a depressed presentation.

MS ABRAMSON: Can I ask one final question, and happy to take this on notice if need be. Do you plan to evaluate your strategy, or do you have any data or evidence on its effect?

MR MARKS: So it's a 2018 to 2020 strategy. We will definitely be evaluating it. It's difficult - I mean, we have an online automated quality feedback questionnaire that all of our students that use our service get once after their first visit. We do quality feedback from our participants in our programs but that's a very small part of what the strategy is. So how we go about evaluating this - I mean, it's very difficult to look at cause and effect. You can look at retention but then there's many, many factors that come into retention and I've never lay claim to an increase in retention being a direct indicator of the effectiveness of the strategy to be awareness. The number of referrals that we get. So we have to come up with a set of measurables, I suppose, that make rational sense as indicators of the effectiveness or otherwise of the survey.

MS ABRAMSON: No, I understand. Thank you.

MR MARKS: Yes, of the strategy, I mean. Yes.

PROF KING: Thank you very much.

MR MARKS: Okay. That was it? Are there any other questions?

PROF KING: No, thank you.

MS ABRAMSON: No, thank you. Thank you very much.

MR MARKS: Okay.

PROF KING: Next is Andrew Morgan. All right. Treat this as a submission and if we can get an electronic version, that would be fantastic.

MR MORGAN: Sure. I didn't bring the electronic version.

PROF KING: No, if you can send it through though, it will help us. If you could state your name and if you're representing a particular group, that group, and then if you'd like to make any opening comments.

MR MORGAN: Thank you. My name is Andrew Morgan. I'm making an individual

submission. I hold a certificate in psychiatric nursing and a degree in nursing and have practised in the area of mental health nursing for over 30 years. I've got extensive experience in the area of adult acute mental health nursing, predominantly in the emergency department over the last 10 years. I'm a longstanding member of the College of Mental Health Nurses and I'm also a member of the ANMF.

I wanted to clarify the setting in Victoria for mental health nurses if I could. Within the public sector, similar to South Australia, the EBA sets education standards for registered psychiatric nurses. To work as a registered psychiatric nurse at a level 3 you need to have undertaken training in mental health nursing or be progressing post-graduate training and at RPN 4 level you need to have had undergraduate or postgraduate training in mental health. Most private settings have similar expectations.

Whilst there is much to support in the draft report, I wish to talk against the reports draft recommendations no. 11.3 with respect to the undergraduate mental health nursing training and the separate mental health nurse registration. The report argues that the number of mental health nurses practising in Australia in GP clinics, community health services and the aged care facilities should be significantly increased, and I don't disagree with that expansion.

However, the report highlights that the only way to grow that workforce is to introduce undergraduate training and separate registration. It somehow sees this as a way to change what it sees as a poorly valued profession into a highly valued profession. It has a perception that the current mental health nurse-force lacks training. I disagree with both recommendations and believe that the status quo with respect to training should be maintained and expanded.

In my view, the report provides no or very poor evidence to support the recommendations and I will talk to three points with respect to that.

The draft report's graph, figure 11.5, reports to list those nurses with specialist mental health nursing qualifications is incorrect. The report wrongly assumes that only credentialed mental health nurses and those nurses where solely qualified in the area of mental health nursing via APRA, and they're essentially the migrant UK mental health nurses, as the only nurses with mental health qualifications.

The reality is that most of the nurses with mental health nursing training are registered as RNs only and so it won't show up on any statistic as having specialised training. To support this view, in the acute community team where I work a search of the Nursing Board database reveals that of the 40 permanent mental health nurses on staff, 28 have mental health nursing qualifications. Of those, 20 have undergraduate training and 8 have postgraduate training and five are overseas trained with mental health training. All are listed in APRA as RNs. Although all would be eligible to apply for the College's credentialing, only one has. None of the overseas trained nurses have the notation 'solely qualified' in the area of mental health nursing on their registration. What this shows is that only one of the 28 nurses on my team who fit the criteria as a mental health nurse will be listed on the graph shown in the report. Simply put, the graph doesn't show a complete picture of those specialist qualifications and I would suggest the graph massively underrepresents the number of specialised mental health nurses in practise currently.

I wanted to talk to the Australian College of Mental Health Nurses submission to the Commission. The draft report appears to rely heavily on the submission from the college and envisages a prominent role for the college with respect to workforce planning and training. I wish to point out that the college has no legal entitlement with respect to establishing standards of practice for mental health nurses. They don't govern practice in the same way as the various medical colleges do. I am concerned that the college's preference for credentialing led to a bias in the data it provided. The data supplied by the college on figure 11.5 only shows credentialed nurses, not the 1500 or so other mental health nurses that are members of the college.

I am also concerned about the inconsistency in the college's direction with respect to mental health training. The college's submission argues that nurses employed in mental health services should be appropriately qualified. That is, they should be registered nurses who have postgraduate mental health nursing qualifications.

But at the college's recent AGM two motions were put up which contradicted the college's submission to the Commission and coincidentally directly supports the recommendations in the draft report. Motion 1, to create a separate mental health registration, won by a show of hands. Perhaps a 60/40 split. Motion 2, undergraduate mental health nurse training was defeated by, I think, two votes. Only approximately 250 of the 3,000 members of the college that were eligible to vote voted. Hardly a glowing endorsement of the motions or of the report's recommendations in 11.3.

The Commission should also note that the college is currently without a CEO, and as a consequence almost half of the paid staff have resigned from the college.

I wanted to talk to the report's mention of a UK model of undergraduate mental health nurse training. The report essentially highlights its success. However, this appears not to be the case. With the MHS, mental health nurse, workforce down by about 6,000 in the past 10 years, with difficulties being experienced with worker burnout and recruitment into undergraduate training. I support the maintaining of the status quo. In my view, mental illness and physical health are clearly linked. It could be argued that the crisis to mental health care is because of a chronic attitudinal and funding disconnect between the two. In this context, a mental health nurse needs a physical health knowledge that comprehensive undergraduate training can provide. As a profession, nursing wouldn't benefit from the forced separation that separate training and registration would lead to. It risks the attitudinal gains that are apparent in the current nursing workforce.

Those that seek undergraduate mental health nurse training have not been able to demonstrate that it would create a cohort of new graduates into the field. The report doesn't provide any research that supports this notion either. Recent research suggests that there are actually an increase between 2013 and 2017 in the supply of mental health nurses from 8.3 EFT to 8.6 per 100,000 of the population, not a decrease, so something is working.

In my area of mental health network, of 149 graduate nurses commencing in mental health programs for the years 2013 to 2017, 30 per cent have gone on to complete postgraduate studies in mental health within two to three years.

I understand there was little difficulty in attracting new grads to work in mental health. We need to continue to provide and develop new support mechanisms to encourage this group to complete postgraduate training and continue into the mental health field.

Consideration should also be given to funding a program that would provide a wage to those undertaking a full-time postgraduate diploma and embed them into community mental health services. In Victoria this could easily be an expansion of the existing community training positions already in existence.

I'm happy to take any questions.

PROF KING: Okay. Thank you very much, Mr Morgan. Just a first one from me and then I'll pass over to my colleagues. Is it your view - so I note that you've said there's been an increase in the number of mental health nurses per 100,000 population since I think it was 2012, 2013 period.

MR MORGAN: Yes, yes.

PROF KING: Is it your view that there are enough mental health nurses, that we're in a pretty good situation, that the flow-through of new graduates is looking pretty good? So that's the first question, so I'll let you answer that one.

MR MORGAN: Sure. Okay, no, there isn't enough.

PROF KING: Okay. In which case - I just wanted to check before I went to the second part of the question, which is, well, that was our view in the draft report and so we were trying to think of ways to increase the number of mental health nurses, and you've suggested that we've gone down the wrong track.

MR MORGAN: Yes.

PROF KING: And thank you for your submissions to us. But then what would be the alternative? What should we be recommending to increase the mental health nurse workforce?

MR MORGAN: I think you need to look at the current model and improve on it.

PROF KING: Suggestions for how to improve on it?

MR MORGAN: Well, one of them is my suggestion in item 4 at the end, so you could in fact provide a wage to undertake a fourth year in nursing, remembering that nursing is a three-year course, not a four-year course like our allied health colleagues, so you could introduce a fourth year, which specialises in mental health, and you could somehow link that to clinical mental health centres as some kind of graduate entry program, for instance. That hasn't been tried, to my knowledge.

PROF KING: We heard during our inquiries as part of leading up to the draft report, we

talked to both teachers, we talked with a number of mental health nurses, including some recent graduates. It was put to us that one of the major pushbacks on more mental health nurses is that there is stigma within the training and within the profession towards mental health nurses. For example, it was put to us by a new graduate that they were told that going into mental health nursing would be a waste of time, that they would be destroying their career. Another one said, 'Well, of course, you need to do real nursing. If you want to do mental health nursing later that's fine.'

MR MORGAN: Yes.

PROF KING: So those sorts of comments weren't uncommon, and again, that's part of the reason why we went down the direction that we did, because of dealing with the stigma. So do you believe there's a stigma there and if you do, again, how should we be dealing with that stigma to stop it being a barrier for more mental health nurses?

MR MORGAN: Sure. I suspect there is stigma between medical specialties, so I think that that's what you're describing. Some undergraduates would like to work in mental health. They clearly do. In our network, there's little trouble filling the graduate program for mental health nurses, and obviously some nursing graduates don't, and they will vocalise that. I don't think it's any more complex than that.

The suggestion that an undergraduate mental health program will somehow provide a body of students - I'm not sure where that's coming from. You know, there's an expectation that, say, 18 to 21 year olds finishing VCE will line up to do undergraduate mental health nurse training. I don't see any evidence that supports that and I think it would be a much better way to increase the mental health nursing workforce would be to work on the existing undergraduates and improve that notion that mental health is an unhealthy place to work in. How do you do that? I don't know. Integration - the generalist nursing program has really only been around, certainly in Victoria, and someone might correct me from the floor, for about 10 to 15 years, so it's actually relatively early days, yes?

I am the last of the hospital trained, meaning institutional trained, nurses, and I'm 54. There's probably a couple that are 53, and we're the last of them. But behind us are a whole group of nurses that have postgraduate studies and some of them actually did an undergraduate mental health nurse program that existed for a period, and I think that it's clear that behind them as well are these new nurses that are completing postgraduate studies and given time that stigma will dissipate. I'm highly valued in my ED. I'm not looked down on. When I walk in, people are comfortable that I'm there and that's because they appreciate a nurse that can work in mental health.

PROF WHITEFORD: I have a question. So we've spoken to a number of employers, including in the private sector, who told us that they have just been unable to recruit Australian-trained mental health nurses. The only ones they - one employer told us it's been two years since they've got a new mental health nurse from within Australia. They've got them mainly from the UK, and they pay more, their working environment that I physically saw seemed to be attractive compared to acute public sector mental health and so the perception that there's mental health nurses with RN training who aren't recognised by a data set that we can use. Have they chosen not to work in mental health even though they're RNs

with mental health training, and if so, how can we get them back into mental health if they have that training but have moved out?

MR MORGAN: Are you refereeing my comment about how they're – - -

PROF WHITEFORD: Yes.

MR MORGAN: No, I think they're there. My comment really is that the report isn't accurate with respect to how many RNs are mental health trained.

PROF WHITEFORD: Sorry, so let me just clarify. I might have misunderstood what you said.

MR MORGAN: Sure.

PROF WHITEFORD: So were you saying that there were RNs with mental health training that are still working in mental health or - - -

MR MORGAN: Yes, I'm one of them.

PROF WHITEFORD: - - - these are RNs with mental health training who are no longer working in mental health; they're working in other areas of nursing?

MR MORGAN: No, I'm saying that your report massively underestimates the number of RNs with mental health nursing training that are working.

PROF WHITEFORD: In?

MR MORGAN: In mental health.

PROF WHITEFORD: In mental health. Okay. All right. So that even all those nurses who we haven't captured, you'd said in the report, the employers are telling us that despite that number, they are still struggling to get mental health nurses and have to import them from overseas. Is that your understanding in the areas you've worked or the colleagues you've spoken to?

MR MORGAN: Yes, there is, yes. Agreed, yes.

PROF WHITEFORD: And a suggestion for now to tackle that in the short- to medium-term?

MR MORGAN: Well, I think I've addressed that. Like, I don't think enough thought has been given to how we progress graduates of comprehensive nursing into mental health.

PROF WHITEFORD: And then by – - -

MR MORGAN: So, I mean, that's not my deal. I don't work in that area. You know, I don't recruit, yes? I think it would be valuable if the Commission spoke to directors of mental

health nursing and got their understanding of how they recruit.

MS ABRAMSON: If I might persist, Harvey - Professor Whiteford is actually reflecting the comments that he had to us, to be honest, that they can't get enough mental health nurses locally, that they're having to recruit internationally. We've also been given evidence during the course of the inquiry that those that - when students do come to them they then make a decision not to progress with mental health nursing.

MR MORGAN: Well, I don't think that's the experience necessarily in the network that I work at, yes?

MS ABRAMSON: I understand.

MR MORGAN: Yes.

PROF KING: Other questions? Comments?

PROF WHITEFORD: Not from me, no.

MS ABRAMSON: Thank you.

PROF KING: Thank you very much.

MR MORGAN: Okay.

PROF KING: Now, because you will be chairing after afternoon tea, when will I break until?

MS ABRAMSON: Well, we could do some (indistinct).

PROF KING: Yes.

MS ABRAMSON: We've got a phone call at 3.30, though, haven't we?

PROF KING: Yes. So do you want 3.40 or 3.45?

MS ABRAMSON: Well, we've got a phone call at 3.30.

PROF KING: Yes, it shouldn't take longer than 15 minutes.

PROF WHITEFORD: Are we breaking now?

PROF KING: Yes.

PROF WHITEFORD: We should tell everybody.

PROF KING: Okay. Ten to 4? We'll take a break for afternoon tea now. Because all three commissioners have a meeting that's popped up in our diary at 3.30, I suggest that we take

half an hour for afternoon tea. Apologies that that's a bit longer than we expected, but that will make sure that you don't all come back here and find no commissioners for 10 minutes. So let's reconvene at 10 to 4.

SHORT ADJOURNMENT

RESUMED

MS ABRAMSON: Well, thank you all for coming back after the break. I notice that we're actually extending the catering to the afternoon which I regard as a very good innovation if I could tell the staff that while we're here. So, look, thank you very much. I just wanted to reiterate a couple of issues. We do have a number of consumers who are going to speak directly and I just wanted to remind those people that we are live streaming the proceedings and we would ask that you are careful about not naming people or institutions, and whilst we don't ask you to take an oath of course we expect you to be truthful in your remarks, and for those members of the media we would be grateful if you could take account of the nature of the evidence that people are giving. So with that if I could just ask Mr Lawrence from First Step if you would announce your name and where you are from and I am sure you have an opening statement.

MR LAWRENCE: Yes, I do.

MS ABRAMSON: I feel like you're very remote over there.

MR LAWRENCE: I feel like I am very remote too, but this is the set up. Hi everyone, I'm the guy around the corner here. I do have an opening statement, but introductory to that my name is Patrick Lawrence, I'm the CEO of a not for profit organisation in St Kilda called First Step. And I shall launch into that opening statement, Commissioner?

MS ABRAMSON: If you would, thank you.

MR LAWRENCE: Which is written. I'm the CEO of Australia's pioneer hub for adults with complex and chronic committal illness. Across the Productivity Commission's draft report three words appear almost 500 times; I did the searching; integration, collaboration and team; nearly always to describe what should be, not what is.

At First Step we've been perfecting multi disciplinary outpatient care adults for 20 years, with no fees for clients, no referral required for most of our services and an attitude of unconditional positive regard. First Step also embodies non-judgment, trauma informed care, accessibility and the policy of no wrong door.

Reading through the Productivity Commission's powerful and comprehensive draft report it seems that the Commissioners were unable to unearth convincing examples of integrated outpatient care for adults with mental ill health. I am here today to point out that you missed one, if I can be so bold and cheeky. First Step are not for profit mental health addiction and

legal services hub in St Kilda. But it's not just a collection of independent services on one site, First Step is an integrated team of highly skilled, highly qualified clinical and non-clinical staff who collaborate constantly in the planning and provision of treatment to our clients.

This goes way beyond warm referrals at a single convenient location. This is detailed initial assessment and the formation of a purpose built multi disciplinary team for each client which can grow, change and reduce in size and scope, step up or step down, according to the client's ongoing needs.

It's important to understand the breadth of expertise and support we're talking about here all in one building. This is a long list. We have GPs with clinical nursing support; addiction medicine specialist physicians; psychiatry, psychology, both clinical and counselling psychology; mental health nurses, care coordinators, drug and alcohol therapists, peer workers, group therapists and family therapists. We also have psychosocial workers with access to brokerage funding; gastroenterology, Hep C, and a community legal centre. In fact it's the only criminal law practice within a health practice in the entire country with the possible exception of indigenous health.

What we aim for at First Step is incremental whole of life improvements. Any advances in recovery will be held back by the weakest link in the chain, for example harmful substance use, which is an incremental whole of life improvements are not a realistic goal without a multi disciplinary team working from a single site.

At First Step we see many people at the lowest point in their lives, and our ability to stabilise, support and empower them has led Professor Patrick McGorry to describe our approach as, and I quote, 'Exactly right to tackle the tenacious co-existence of mental health and drug and alcohol problems and it's having great results.'

We treat two and a half thousand people every year, support more people on opiate substitution therapy than any other clinic in Victoria, and we've developed a peerless reputation among service users and indeed other services in the south east of Melbourne. In conversation with clients I am forever being told, 'This place saved my life.'

The critical element of First Step is our multi disciplinary model, and its obvious benefits are the immediacy of secondary consultation and ongoing collaboration. But this approach has structural, attitudinal and indeed ethical elements that create a unique eco system with countless benefits to clients, practitioners and the community. I will list just a couple of them.

We have a much greater capacity to manage risky or highly at risk clients including serious violent offenders through the team approach. We can ensure continuity of care as patients are stepped up and stepped down within the same organisation, not being referred to somewhere three suburbs away in two months' time. We minimise the risk of people falling through the cracks, a phenomenon that we're all familiar with, and we have daily inter disciplinary conversations that expand clinical knowledge. You can imagine that you're going to learn more from working with a psychologist if you're a GP than if you're going to learn from

working with another GP for instance, and if you have mental health nurses and psychosocial workers we learn a lot.

In closing: cost. The Productivity Commission estimates $1,200 plus for an acute bed for 24 hours; non-acute almost $600. The Council of Australian Governments provides figures of $300 to $400 per day for incarceration in Victoria. At First Step with intensive support multiple consultations every week from a team including a GP, mental health nurse, care coordinator and psychosocial worker, ongoing legal support and two monthly appointments with a psychiatrist, the cost of all those services together over the course of a year would be just $29 a day.

That includes organisational overheads so that the place doesn't fall into a hole in the ground, and the calculations and funding sources are detailed in this handout that I will give you in a moment, but I will wait a moment or else you will just be absorbed by that I'm sure. Twenty-nine dollars a day; comprehensive multi disciplinary team care in the community of a kind unique and intensity to First Step. For one-tenth of the cost of incarceration or 6 per cent of the cost of a non-acute hospital bed. And it's about getting better.

The goal all the while is to stabilise, support and empower our clients. For most people reliance on services will reduce over time, which is the exact opposite of what typically happens when someone is released from prison or discharged from hospital, often without adequate supports and often in practice into homelessness.

In an urban setting the First Step model is absolutely scalable and replicable by other organisations across the country. First Step looks and feels like a friendly GP clinic and is mostly funded through Medicare and through the primary health network, in our case the south eastern primary health network. Both of these systems obviously apply all across Australia. The Productivity Commission's draft report identifies an upper limit of approximately 250,000 Australians needing intermittent care with, quote, 'Episodic or persistent severe mental health and complex needs.'

To support the most vulnerable 10 per cent of that group in the manner, the intensive manner that I've described above would cost 300 million per year approximately based on my calculations. That's for 10 per cent of the most at risk a quarter of a million.

The health economists can calculate - I'm sure there's plenty of them here - health economists can calculate how much of the annual burden of 180 billion identified by the report would be saved by this intervention, in terms of reduced hospitalisations, reduced imprisonment, reduced welfare payments, decrease deaths including suicide, and increasing wellbeing social connection and participation, but it would be expenditure in the millions for savings in the billions.

The Productivity Commission needs to closely examine First Step, I would say, and consider our successful model in its recommendations with regards to, (1) closing critical gaps in healthcare services, which we all know is reform area 2, and fundamental reform to care coordination governance and funding arrangements, reform area 5. I extend a warm welcome to the Commissioners, to their staff and to anyone here in the room to visit First Step any time. Thank you.

MS ABRAMSON: Thank you very much, Mr Lawrence. Did you have the document, you want that tabled as a formal submission?

MR LAWRENCE: Yes.

MS ABRAMSON: Thank you.

MR LAWRENCE: That's tabled out. So it's a generic document about First Step as well as the specific calculations - - -

MS ABRAMSON: Thank you. Can I ask you, like the model is really interesting, so two parts to it. The first part is how did you build a system, and the background to my question is when we've looked at difficulties with integration a lot of it has seemed to be around cultures and around the way that people work. So there's a health system culture, there's a culture within social work. So how did you get your model operational?

MR LAWRENCE: I think a key - well, the history of the organisation is that it started with a GP and we were doing rapid detox of opiates and they will check (indistinct) implants in the back room. I don't know if anyone here knows First Step, in the old days it was pretty fascinating back then. But I think the main answer to your question is that the teams are small and that familiarity with - the team is small. There's a total of 28 people who work for First Step and the full-time equivalence is 16, and the mental health nurses and the care coordinators and the GPs and the psychologists and the psychiatrists work together all day every day.

So their main modes of communication are actual case conferences that can be billed for the GP, which is a GP plus two other health workers. We have regular clinical meetings where patients who people are concerned about or want to discuss are discussed; of course that's every couple of days, and simply knocking on the door of one of your colleagues and saying have you got five minutes probably happens at First Step literally 30 times a day.

So they're working hand in glove and they come to appreciate each other's skills and expertise. It is so totally different from a written referral by a GP to a psychologist three suburbs away in two and a half months. It's the absolute opposite of that. You can imagine if people spend a lot of time together they learn from each other, and of course the staff have a particular interest in that multi disciplinary work as well. We attract people who like doing that kind of work, and I would also add this is not for people who have just finished their Cert IV or straight out of school, it's highly complex work and it does need skilled staff.

MS ABRAMSON: Do you have a view as to why - or maybe it has been used in other states and in other regions. It's the scalability issue.

MR LAWRENCE: Yes. Why is it not more common? I actually don't know. I mean I think the history of siloisation - I mean of course you've got physical health which is broadly speaking funded at a Federal level; mental health which is funded more frequently at a State level, although the PHNs make that all a little bit complicated. There's just silo after silo, and when we look at these bumper GP clinics it's kind of crazy that here's a wonderful big clinic

full of GPs. That's a culture that's developed. I don't know that that's good for billing and other things. How great would it be if every one of those clinics had two or three GPs plus plus plus all the services I've listed below.

Certainly in the area - working with severe and complex mental health, which we find is more frequently connected to addiction than not, and usually stems, and I have to add a caveat, this is not applied to any particular person and it certainly doesn't apply to anyone in this room, but this severe and complex enduring mental health where your life is at risk for 10, 20, 30 years is usually connected to significant childhood trauma, and I just don't think we've developed a system where we've though, okay, let's really do an amazing job of looking after that group of people.

MS ABRAMSON: Do you think that the funding models have really worked against integration?

MR LAWRENCE: Yes, absolutely. It's very difficult - you know, we've got a small team. Of the 28 people there's three of us who don't work directly with clients, I'm one. So we're very service focused and to chase down all the necessary contracts we were very lucky that we formed a strong partnership with SEMPHN, the South East Melbourne PHN, without which we certainly couldn't be doing this work. I think that it's fair to say I would want a lot of services to replicate First Step, but not without some additional government support.

We are not really financially sustainable. We manage, we sort of scrape through from year to year with a lot of help from philanthropy, but when we're talking about overall expenditure the Federal Government's proposal for eight new pilot adult mental health hubs across Australia they're talking about $16m per year per hub, we need about 200,000, 300,000 to stay financially sustainable, and the best thing about those two funding sources they talk about, the PHN, that's in place, it's there, and Medicare - well, you don't even need to apply. I mean it's a guaranteed source of funding for GPs in that context.

MS ABRAMSON: Of course it pays for some of your services - - -

MR LAWRENCE: Of course it does.

MS ABRAMSON: - - - but not all of them.

MR LAWRENCE: Yes.

PROF WHITEFORD: You said funding comes from the South East Melbourne PHN, philanthropy and billings to the MBS through the health providers who work within - - -

MR LAWRENCE: That's correct. Like normal GPs they pay a percentage of the billings as rent at First Step.

PROF WHITEFORD: The State Government?

MR LAWRENCE: Very little at the moment. We've had some support with building upkeep and we - First Step Legal that are hardly talked about but is really quite an amazing

part of what we do is significantly funded by the Department of Justice and Regulation at the moment.

PROF WHITEFORD: The second question relates to I guess the cohort. Are they clients or consumers that you have the service for an extended period of time, like years here?

MR LAWRENCE: Yes, they are.

PROF WHITEFORD: And if so is there - if there's no flow through of clients is your intake therefore limited by your capacity to manage the clients current on your books?

MR LAWRENCE: It certainly is, and I need to clarify that in the last financial year we saw just over two and a half thousand people. A lot of those people are connecting with us to support them through opiate substitution therapies. So we're seeing them at a varying basis, but sometimes once a month or once every two months. Methadone and Suboxone, there is more evidence linking them with reduced negative outcomes than any other drug treatment available at the moment, and we certainly believe that they are appropriate for a lot of clients.

One of the benefits of that it's sometimes described as chemical handcuffs, and I can fully appreciate that, but sometimes we will have clients that will stay connected with us through that process and then things go wrong in their life, a partnership ends or a parent dies or children are taken away, and that's a very common part of our work, and we still have that client engaged, partly through the opiate substitution therapy. That's one source of having people engaged for a long period of time. But really when we have someone who has a very complicated childhood history of abuse and neglect we expect to be working with them for a couple of years at least, and certainly we have some people who we anticipate supporting for the rest of their life as long as they need our care.

PROF WHITEFORD: And the last question, sorry - and so what does that do to your intake, like what - - -

MR LAWRENCE: Yes, sorry. Well, at the moment - so technically you walk in the front door at First Step and ask to see a doctor, and you would. At the moment we can't take walk-ins, we're effectively closed because we are at capacity and we can't get you in front of a doctor for six weeks, which is quite a recent turn of events, it's been the case for about a year. We still take the most complex clients no matter what our capacity, because we know that there's no one else really in the outpatients sense who can work with them, but the PHN funded programs are - we have what's called mental health integrated complex care which is the complex end of stepped care, so below the public mental health system and hospitalisation. There's mental health integrated complex care.

That steps down to access to psychological interventions - sorry it's so jargonistic - but clients are stepped up and stepped down through that program and ending their contact with First Step when things are going badly or a lot better. But also any drug and alcohol mental health organisation will have people that just stop coming. We certainly have that. Loss to follow up is not an uncommon outcome, and sometimes we think, well we've done two years of great work with this person, we don't know where they are now, but we know that at least

they were well for those two years, so sometimes that creates capacity within the organisation. It's not something we celebrate, but it is an aspect of work in this area.

MS ABRAMSON: Could I ask about First Step Legal. We've got a lot of emphasis in our report on diversion, and I'm just really interested that kind of your model is the legal side of it and whether that's mainly an interaction with the criminal law you talked about having a cohort with drug addiction, or whether it's the civil issues as well.

MR LAWRENCE: No, it really is criminal law and family violence law. So our team works almost solely in that area, although we do a lot of work in the space of fines through something called work and development permits, which I can never remember because it has the worse name ever, which means attending the clinic to pay off infringement fines. So that's something we do clinic wide. In fact we've paid off about half a million dollars' worth of fines in that manner. By paid off I mean they were waived when we provide evidence that they have been attending this session and that session, but the work of First Step Legal they have an unashamed goal of keeping people in the community and linked to their families rather than being incarcerated for crimes related to their addiction. They can be directly drug related crimes. There can also be crimes of theft and there can be crimes of violence during that period in people's lives as well, but that's very much the focus. We were the first health justice partnership really in Australia, and partnership isn't really quite the right word, First Step Legal is just part of First Step. It's not a partnership, it's part of First Step, like the GPs or anyone else.

MS ABRAMSON: Could I also ask whether you've had any evaluations done of your program or whether you intend to have any?

MR LAWRENCE: Fabulous question, Ms Abramson. It is - we've been working up to that. So we've had - we've done some theory of change work that I'd be happy to provide to you, in fact it's in this document, with Social Ventures Australia. We now have two ongoing research partnerships with the University of Melbourne, School of Population and Global Health. One is a global literature review of clinics as similar as to ours as we can find. That literature review is underway at the moment, and we have just recently - we're applying to the Ian Potter Foundation and we have applied to Freemasons. We'll apply to Vic Health to do a longitudinal study with our own clients through surveys and linked data, so looking at things like hospital admissions and incarceration during a period of time before people attend the clinic and then during their time at the clinic. Probably not after, I don't think we've got that much money, but we're working very hard on that at the moment, and Professor Jesse Young has particular expertise in this area and is sort of our man on the inside at University of Melbourne.

MS ABRAMSON: Good. It's very interesting and thank you for making the time to come to talk to us today. Harvey, did you have - - -

PROF WHITEFORD: Thank you very much.

MS ABRAMSON: Thanks very much.

MR LAWRENCE: It's very much my pleasure and I extend again that invitation to Commissioners or staff - - -

MS ABRAMSON: That's a very interesting invitation.

MR LAWRENCE: Come on down.

MS ABRAMSON: Thank you. Thanks very much. Could I please call the Health and Community Services Union, and if you would be kind enough when you take your seat to announce your names and where you are from.

MR HEALEY: My name is Paul Healey, I'm the state secretary of the Health and Community Services Union. We're the union that covers mental health and disability in Victoria. We've been around since 1911 and been very much focused on working in the mental health area with staffing and also been very active in advocating for better services. I worked in mental health myself for 26 years. I started at Brierly in Warrnambool and worked at Larundel and Bundoora Repat and then I finished my career working at the Royal Children's Hospital Adolescent Psychiatry which I found to be an exciting job and lots of fun, and used to be embarrassed sometimes to get paid because it was so much - so enjoyable working with the young people.

We have looked at the Productivity Commission's report and we've just picked out five or six things we'd like to speak to if you don't mind, and the first thing is about the recommendation 7.1 about determining (indistinct) paying for beds and acute services for subacute (indistinct).

We believe there needs to be a really strong integrated approach so that the right bed, the right service is there at the right time for the consumer. I'm a great believer in choice in that the consumer should have a choice for where they need to go at the time of their recovery. I also believe that it should be very much in preventative model so people get in early and have the right opportunity.

I heard earlier today about vacancy rates and I think, you know, lower rates, having beds available at all time is a really important thing for people to be able to step up and choose. We had a model when we worked at adolescence where young people had vouchers where they could ring up and within 24 hours we'd admit them, and that stopped all those crisis, people self harming or getting the police and ambulance involved, they'd bring themselves to the unit and that was a fantastic way that we made sure we had opportunities for people (indistinct) and they need to be there.

In Victoria at one stage we'd have 3,200 beds and currently we've got about 1,400 beds and with the population doubled it doesn't meet the needs. We also believe that diversity of bed stock should be expanded in subacute forensic AOD and step up step down, even (indistinct) split CAMHS with the growth in young people, and also to review to actually meeting the needs of the future population.

We are a great believer in building hubs that are connected. We look at both bed-based and community-based hubs where people come and have all the needs met and all the things. For the community-based hubs we really think it is about building community, not just about

service, that you have places to go and that all the things you require for your treatment, AOD services, legal services. We also believe there should be art galleries and libraries and cafes and social ventures there so that people can go there and build community. Also indigenous safe spaces and actual community spaces. We think that's a model, and it's been seen overseas, that would work well in Victoria, particularly in the outer suburbs and also in the regional area, and we've picked out a spot in Bendigo, a nice spot to build our first hub if we can ever get one built, so we think it would be fantastic. That's one.

Recommendation 8 about alternatives to emergency departments for people. We absolutely agree. We think that the general public emergency departments are no place for someone to have (indistinct) illness. We actually very strongly support re-establishing the CAT teams and outreach teams so people can be treated in their homes, that people can get the services they require. I met a gentleman who walked up to me when I was on a picket line one day and he just said, 'I remember the old days, it was much better. I used to just ring up and they'd come and get me. Now I just stay sick, and if I want help I go to the library and play up and then they take me away', and he said it was not of assistance because he can't stand being in the ED department; it's too bright, too noisy and too distressing. So we think that outreach works, but also with the hubs, the hubs are designed that people know they could go to those places and reach out, and I think the Haven Café that St Vincent's runs is a great idea as well and you have a mixture of clinicians and peer workers and consumer care consultants there to help.

Very much about peer led services to welcome people and support people through their journey and to help them in urgent need. We are one of the first - I think we're the first union to have a proper peer worker EBA and to have the proper career structures path and wages and conditions, which we brought in eight years ago and we continue to develop. We're looking to develop that as sustainable careers, so we believe there's got to be four streams; one is research, one is education, one is practice and the other one is management. I always forget one out of four, but particularly the education, we think to build sustainable careers you need that educational support and that supportive supervision to actually aid people to develop their skills and maintain their careers.

In recommendation 11.3, direct entry training, that's where I started, I did direct entry training. I found it to be a really great way to start your career. At the time when I signed up I was unemployed or doing labouring work and I was able to get in as direct entry and start working, and you learnt your skills and then you did your training in blocks and went back and then consolidated what you learnt. So it was a really strong way to build your knowledge, but I don't think that one size fits all. I actually think the models we have as well, the postgraduate and grad works as well, and if I had my way - and I also believe that cadetship model as a third tier to it, that you bring people into mental health who have life experience.

For consumers they need people who have a diversity view and understanding and people who understand what they've done and where they've lived, and so when I started working I worked with all sorts of people who had various careers. My dad worked in mental health. He was a banker before he went into mental health. I've worked with shearers, plumbers, all sorts of people, and also it gave the opportunity for women coming back into the workforce after having kids and they were able to get into direct entry and was able to do it, and that

was really good. I know when I was a clinician I was very critical of parenting until I became a parent and realised how difficult it was and it changed me significantly in the way I work with families and understanding of what they are doing. So that understand, that life experience makes a huge difference to not only your practice but to the consumers you work with.

In Victoria we've currently got 450 vacancies in mental health nursing. There's 12 beds currently shut in Victoria because we can't get the staff. We're advocating for an extra 180 graduates a year, both nursing, allied health, so social work and OT, to actually develop a workforce in a much quicker way, and we've been lobbying for that over - for the next five years to get 720 staff, because no matter what happens out of the Royal Commission and other things that are occurring we won't be able to open services until we get the staff. Mental health is labour intensive, it takes time and takes people to sit down and work with people to understand them. It's that relationship you build with the consumer, but it's also the diversity of people that the consumer wants. So sometimes the nurse is not the right person for them, another peer worker, social worker, so it's about the diversity, a carer, that diversity makes a huge difference to the outcomes.

So we believe that the mixture of the three would be the way to actually develop the workforce, and I think that would give it longevity and a really strong workforce making sure you get plenty of people. Social work and OT currently in Victoria have no access once they graduate into mental health. There's no graduate programs, and we're advocating very strongly a two year of consolidation of practice, and that way to build them up, but generally speaking they had to go out and work in child protection or some other area and then they come back to mental health. So we think there's a role for a two year program for allied health as well to be built up, to build your workforce up.

Specialist registration: I never left - even though it changed with APRA I still wrote RPN on my notes when I changed my registration to an RN. I never changed, I was an RPN, I still refer to myself as an RPN. I think it's very important, and one of the most important parts is that actually if you have that specialist registration you can actually track and follow where the staff are, the nurses are, and what their registration is and how they work, so you can actually really work out quite clearly where the shortfalls are, and whose doing what.

I think that the more people that get mental health training the better it is. There's such a diversity of jobs and demand for mental health skills. You see - every new reform I get very excited, at the same time I get very scared because it's diluting the pool, and recently there's been 160-odd nursing clinical jobs put in schools and I think that is absolutely great, but it's 160 people coming out of mainstream, and plus because we're talking about the silos and things not working together, those people are employed under education, but they have no direct linkages with mental health services, and so they're left out on their own, and I think they should have supervision and support from the mental health services, also the ability to refer and work in a collective way.

I think any reforms that have people working in isolation is not going to work and it just puts a lot of pressure on the clinicians and it wears them out because they become responsible for all the difficult consumers in schools, so the kids in schools, and if you look at one in five in a school of 500 that's a hundred kids, so it's a lot of kids for one or two people to be looking

after. So I think they need all the support they can and the linkages, and the linkages are the most important thing where you get the experts. Clinicians are very good at identifying things wrong. They mightn't always know how to fix it, but if they can get to the experts to get them in and refer them through then you can actually make a big difference. So I touched on that one.

Recommendation 11.6 about negative perceptions, I personally - I guess the stigma comes through pretty much from TV and movies and how we're portrayed. Mental health nurses are portrayed to be big thugs in white jackets, and in actual fact it's 70 per cent women and there's not many big blokes, so it's not like that at all. I think while the system's in such a crisis phase as we're running at the moment there is a very negative thing. My niece has just started, she's a postgrad this year, so she's third generation in mental health in our family, and she absolutely loves it, and she's telling all her friends about all the great things.

The thing I used to love about it was when you had time to spend time with people, and, you know, I would spend sometimes six to eight hours with one adolescent playing games, and that's how I'd spend the whole shift, and it was fantastic. So you got to know the young person. You were working constantly about how to change what they're doing. You might teach them - I used to teach them to swear appropriately at the right place at the right time, which was a good thing because it stopped them getting kicked out of school, and things like that, getting to know the young person to understand how they are, and all day we'd have a dialogue going, not necessarily to look like it's therapy, but you'd have this dialogue going that you're talking about and shifting them what they think about things.

So I think if the systems change and it wasn't so crisis driven and that people had time to actually do the really core great work that we do and love it would lift the stigma significantly for staff to go and work in there because it's such a skills-base, and there's nothing better than, you know, you started a new hobby or something and bring it to work and start teaching people and run a group around that hobby, and we had music. I did adventure-based counselling at some stages when I had the knees for it, and climbing, rock climbing, and it was fantastic. So it's a really great job where you bring your great life experiences into the work and help people and you learn a lot. I think that's all I've got to say at this stage. Thank you.

MS ABRAMSON: Thank you, Mr Healey, we have got some questions. I did want to ask you though, I apologise if I didn't before, you've left a package of material with us. Do you want that treated as a formal submission, which is the best way for us to have things on the record?

MR HEALEY: Yes, please, yes.

MS ABRAMSON: Thank you.

MR HEALEY: Thank you.

PROF WHITEFORD: So one of the concerns that's been raised in the submissions that have come to the Commission relate to some of the community-based work, especially the mobile community-based work, and I met a whole lot of nurses, and the concerns about

occupational health & safety and the impact that's had on how many nurses can go out, one or two, and where they can go and what they can do, and whether there should be other first responders there, police or emergency services, paramedics, et cetera. Can you just comment on the impact that's had on the delivery of community-based care, especially mobile community-based care?

MR HEALEY: Yes. It's really been wound back over time. So when - I will use an example when I started training - we used to go to Portland which is an hour drive there, an hour drive back, and we'd go and visit a gentleman just to have a coffee. That was our job, once a month go and have a coffee, and that contact with that man meant everything to him and that kept him well, and that's all we needed, just needed to someone to actually acknowledge him being there, and we missed one month for some reason and he ended up in hospital a week later. So I'm a great believer in that you need those resources out there, but I think there's great benefits in having clinicians working with the police, riding out in a pacer. There's great benefit with the ambulance service which we're seeing as a trial in Geelong, but I also think there needs to be outreach, and you may need two clinicians, you may need a clinician and a peer worker, and I think we've got to look at the different groups of people and work in, not a one size fits all, but in a very smart way that suits the consumer, and by knowing the people who they are while actually working with them and knowing what suits their needs, and having that outreach is very important, and also it's about supporting the families. You can't underestimate the work that the families do and how they support their loved ones, and by us coming into their home and understanding their homes and how they work and giving them support at the time when you're there makes all that difference rather than queuing up at ED in crisis, and sometimes just acknowledging families what a great job they do is enough for them to keep chugging along and helping their loved ones.

PROF WHITEFORD: Sorry, one more question. Over time that you've been working in the area, especially as your union covers a number of different fresh groups working, have you seen a change in the mix of types of workers coming into mental health?

MR HEALEY: Not really, but what I have seen is the change of role. So they've made it very generic and I think that's poor. I think you need to have the specially skilled nursing, OT, so as to work those speciality skills. I think you sometimes do need generic case managers because it's easier to hire people, but I actually think those specialty areas, specialty skills, and we have now seen the emergence of the peer workers. We've had care and consumer consultants in Victoria for a long time, they're skills and knowledge makes a huge difference in the way they work. So having that whole team, and we've heard earlier about how the whole team works best, and when I started in CAMHS we had one of everything I used to say, and it was having those different eyes and ears and the different types of therapies available for people who had their own expertise and skillsets made a huge difference to the young people and their families because there was always something that resonated with them, and it's how that resonates with them. I used to say I was in the business of planting seeds and it's about putting ideas out there so people can grab the idea that suits them, rather than us trying to say this is the idea for you, and I think that diversity of skills and staffing is what makes a real difference to the consumer's outcomes.

PROF WHITEFORD: The last question before Julie jumps in. Is the information about the care worker EBA in here?

MR HEALEY: No, but I can send that through.

PROF WHITEFORD: Because I think one of the things that we've heard is how important the role is, but I guess how that's evolved, the differentiation, what that role is compared to other workers, et cetera, and you've had you said going for quite a while, so we would be very grateful to get - you know, develop what you have done.

MR HEALEY: We have a little bit of work to do on the four pillars, what we call the four pillars. We've just been working on that with VMIAC and Tandem and that, so we're just reluctant, but I will send it in as soon as we can.

PROF WHITEFORD: You have got until March next year.

MR HEALEY: Yes, no worries. So we should have it done by then because the EBA runs out next June, and I think it's really strong to have clear career paths and supports to make it a sustainable career for people, I think it's really important, and I look at - I won't refer to them all, everyone covered by EBA as workers, everyone's a worker, and you all come with your own eyes and skillsets, and I think that work in those skillsets in the EBA is really important.

MS ABRAMSON: I just wanted to ask a question about integration and given your experience, and you talked about a previous (indistinct). We did have people who had different skills, but they worked in an integrated way, and you will have observed, and thank you very much for making your comments against recommendations, that's been really helpful, but you've observed that we have been trying to think of systems to in a way force integration, so I'm just really interested in your views about some of the governance things we have been thinking about.

MR HEALEY: I think it all starts with the workers really, because they have opportunities to work across multiple sectors and multiple areas makes a huge difference, and when I worked - I used to be on intake at the Children's, and the big difference was if I knew the person at the other end of the phone I could work out what was going on and negotiate. So because we work in such silos we need to find ways, and I think one of the ways is getting workers work across multiple sectors, I think in Victoria currently there's a great demand for workers in family violence, drug and alcohol, the NDIS and mental health, and I think there should be a way that we get all those workers somehow working across, as they train, across those areas to learn and get skill up. I think as mentioned earlier the funding systems of two streams or more of funding is not useful. I find it's very difficult, but I think that the area potentially has its benefits, but I think I'm a bit of against the smaller - I think you've got to have a scale to actually make things run properly and for recruitment and to run the services. So there needs to be those linkages, but I think the relationships are everything, how you work with people.

MS ABRAMSON: Thank you. Anything?

PROF WHITEFORD: No, that's fine.

MS ABRAMSON: Thank you very much, Mr Healey.

PROF WHITEFORD: Thank you.

MS ABRAMSON: The next person I'd like to call is Mr David Clark. Mr Clark, if you'd be kind enough to state your name. I know that you're appearing I think as a user of mental health services.

MR CLARK: Yes.

MS ABRAMSON: Thank you.

MR CLARK: So my name is David Clark. Just for some background I'm currently on the management committee of Bipolar Life and I'll talk about that in a bit more detail in a minute, and I'm also organiser of Victoria's bipolar/mood disorder meet up group. We have about 400 plus members. And I've also recently become chair of a committee of governance for (indistinct) House, which has delayed me reading your report for which I apologise, because I've been sorting out governance for (indistinct) House, which has been an interesting journey.

Prior to becoming (indistinct) in 2011 I spent 20 years working in the UK National Audit Office and subsequently in Victoria in the Auditor-General's Office. In the UK I was involved in performance audit of the National Health Service, and then went on to the training team and headed up the training program for a number of years. That led to me becoming - coming over to Australia, engaging in a secondment at the Victorian Auditor-General's Office. During that time I was manager of an audit into patient safety which was published in 2004, so a bit of an understanding of the health service in Victoria.

I published my memoire in 2015 and I'm currently writing my second book and I'm looking at blogging and pod casting mental health in 2020. I also have got a few of additional comments if that's okay.

MS ABRAMSON: Yes, we would be very happy for you to take us through those. Thank you.

MR CLARK: Cool. Okay. So there is no mental health system in Victoria, and despite a plethora of Federal and State Government documents, including the Royal College of Psychiatry for Australia and New Zealand's guidelines into mood disorder management and various other publications, the current approach to supporting and grappling with a mental health is minimalistic consisting of diagnosis and medication primarily. The steps can (indistinct) progress, but again who decides at which level care or support is required for the individual grappling with their mental health. The system needs to be reformed through (indistinct) experience, not through psychiatry, although they have a valid advisory role.

There is a wide range of research (indistinct) diagnosis. I only found out what I was healing and recovering from this year, 2011, that's eight years after my diagnosis. My psychiatrist acknowledges the research in (indistinct) bipolar, which is my diagnosis, bipolar 1, is often associated with adverse childhood experiences of which I relate and accept is the likely cause

of my diagnosis, but it should not take me eight years to understand what I need to focus on healing.

Peer support is key and is so lacking throughout the funded health services in Australia. In 2012 I googled bipolar and Melbourne and found Melbourne - it was then called Melbourne Bipolar (indistinct words) Group of which I'm now organiser. I'm also on the management committee of Bipolar Life which facilitate (indistinct) experience support groups across Melbourne and is looking to expand into rural and regional Victoria to support those with a diagnosis. Again I found this organisation through Google.

Only through my tenacious resilience and persistence do I now have a fit for purpose counsellor through the local primary healthcare network, but I've had to persistently advocate for myself, no one has helped me. Since 2011 I have consistently attended appointments with psychiatrists. I have had no support from any other professional such as mental health nurses, mental health social workers, mental health case workers, mental health counselling until 2017. The only way I've been able to understand my diagnosis is through reading books, including personal memoirs on bipolar disorder. These books have been the foundation of my journey (indistinct) recovery.

Thankfully with the agreement of my psychiatrist I am no longer taking medication. This has been a personal choice. The side effects unexplained by my psychiatrist, along with no explanation as to why I was actually taking the medication were debilitating resulting in persistent head pains and daily physical exhaustion. I have been on Seroquel, Lithium, Escitalopram, sodium valproate and luckily Olanzapine. None worked for me. I'm now in a good place with my health and wellbeing, take cod liver oil tablets daily to support my brain's healing and it seems to be working. Again this has been achieved only through self-education and persistent determination to heal and recover from a six month psychotic episode in 2011 for which I was never sectioned despite seeing two different GPs, and a hypomanic episode in 2016.

Along with self-education training to be a life coach has helped me better understand and support myself. I'm now a trained Master Practitioner in (indistinct) linguistic programming and a master coach in (indistinct) link between head brain creativity, heart brain compassion and brain (indistinct), and that book using an (indistinct) brain to do core stuff saved my life. So that's my journey forward in terms of spreading the message. Again self-initiated and again delivering the outcomes required to address (indistinct) post diagnosis.

MS ABRAMSON: Thank you for sharing your story with us. What are the type of recommendations that you would be looking from us that would have made a difference to your experience?

MR CLARK: Well, as I've said information, explanation, planning. There's been nothing, absolutely nothing. My psychiatrist has said nothing about anything, so I don't know - I'm glad they've gone because I don't understand the point of psychiatry. I've had to do everything myself in a way. I will engage with (indistinct), I maintain seeing him every three months for half an hour, but there's been no help at all, so it's that bad, like where are all the (indistinct), and navigating a six month psychotic episode, having seen two different GPs that

were sectioned I have no legal underpinning of my health care, I have no anything underpinning my health care, it's just been self driven.

So that's why I'm slightly annoyed and slightly focused on making sure that others don't have to go through what I've had to go through and hence my connection with a meet up group, and again we hear the same questions, what medication are you on, what's your diagnosis, have you got a good psychiatrist, how do I find a good counsellor, how do I find a good psychologist, and they're just massively lacking, and also with the Bipolar Life providing support groups we are now looking - I'm going to a meeting on Thursday morning, we're looking at developing an online support, something like that to help people, because there's lots of information out there, it's just all over the place. So we're trying to bring it together to kind of guide people through self-education, self-empowerment so they can help themselves, because at the moment it's really not very much.

PROF WHITEFORD: So there's a lot of information out there, you type it into Google. Is what you're saying about what didn't exist for you at the time you needed it was, (1) access to that information, and (2) accessed information which was relevant to you to help you? So you could type it into a search engine, but what came back either wasn't relevant to you and it certainly wasn't what you needed from the clinicians with whom you'd had contact, the GP and the psychiatrist?

MR CLARK: To me where I am now it seems simple and easy, one to make sense of the symptoms. So my symptoms - so the (indistinct) I had is that I had warning signs that would last seconds. They appeared at the age of 19, at the age of 26, at the age of 34, at the age of 40-ish and they are the result of intense stress, work stress primarily, resulting in the collapse in the prefrontal cortex and then you just calm down and go - embarrassed what happened there. So having read people's memoirs they tell of similar symptoms, and when I'm reading these memoirs I'm going, 'Oh my God that's me', presenting at 43 went through again another work situation, extreme stress, my head just exploded and had this psychotic episode which I don't recommend for anyone. Healing that they just dosed me up with three different types of medication all at once.

I've never been into an inpatient ward, I've never had any outpatient support, it's just been have the medication, good luck, away you go, and the side effects were just debilitating and thankfully I'm off them all, and it's only through my own this isn't working and just kind of - even the last six months coming off medication I've gone through a whole bucket load of anxiety going 'Am I okay' every day, every second, 'Am I okay, am I okay', and I'm okay, but again there's been no support and there's no planning, there's no anything, so it's pretty grim.

PROF WHITEFORD: So you weren't connected with community organisation - - -

MR CLARK: There is no community organisations. In Stonnington - I live in Stonnington, there's nothing.

PROF WHITEFORD: Nothing where you are?

MR CLARK: Only recently I have got through the South East Melbourne Primary Healthcare Network a really good counsellor. She's absolutely brilliant, she's gold dust, but it's again my tenacious resilience to say I need someone through the psychiatrist to talk through what I'm experiencing, because I'm talking to you and you're not showing anything. So he didn't - he wasn't able to understand the side effects or anything I would say. It was almost like I was talking a different language, and so for half an hour every three months I would have an exhausting experience with an individual who's supposed to be trained in what I was experiencing and yet there was just nothing. He was definitely disappointing.

PROF WHITEFORD: The last question then. The counsellor you've got now you mentioned, that connected with that person through what - how did you find that person?

MR CLARK: So I did have, I don't even know what it was, some sort of counsellor through the mental health service hospital I was with, but again just total lack of understanding and it was just - some of her behaviour was (indistinct) as well, so it's by email. So I went back to the psychiatrist, he said, 'Well, we put you in touch with a counsellor and it didn't work - full stop.' And I'm, well, it didn't work because she made appointments to meet me and then failed to turn up, and then other times would say, 'I'm in a meeting, I can't meet you now.' Well, that's unprofessional and I just want to make progress and get on with my life. I don't want to deal with unprofessional people. So he was just like, 'Well, I don't know what else there is.' So he was just like, 'Well, there must be something', and it was only through me keep on badgering that he made this call to somebody else in a different part of the hospital and they found there was this South Eastern Melbourne Primary Healthcare (indistinct) counselling service which is only new, two years or so, but that's been brilliant, absolutely brilliant.

People with - people with a diagnosis are exhausted by themselves. They don't need to interact with a mental health system that makes them worse, and that's what the majority of the people I see have to live with. The system is counterintuitive, it actually makes people sicker, it doesn't make them better, and piling on medication after medication after medication, which I got through, is ridiculous, it's unethical.

MS ABRAMSON: Mr Clark, did you have anything else you wish to say?

MR CLARK: No.

MS ABRAMSON: Thank you so much for coming and thank you for sharing your story with us.

MR CLARK: Thank you, no problem, and we'll be putting in another submission.

MS ABRAMSON: Thank you very much.

PROF WHITEFORD: Thank you.

MR CLARK: Thank you.

MS ABRAMSON: And if I could ask Ms Reilly-Browne if she's present to take the stand, and if you would be kind enough to announce your name for the transcript and I understand you're appearing on your own behalf. Is that correct?

MS REILLY-BROWNE: Correct, yes.

MS ABRAMSON: Thank you.

MS REILLY-BROWNE: So hello, I'm Tess Reilly-Browne, and I really appreciate the opportunity to speak here. I am a counsellor in private practice in North Melbourne where I see clients face to face. However I have an inordinate number of clients that seek me via video link because I once had a practice in North Queensland, and old and new clients still seek me out from those rural areas.

I would describe myself as a trauma relationship therapist. I hold a masters of applied social science majoring in counselling, and an early childhood degree. I began my counselling career at Kids Helpline where even though I was still studying my masters they thought I was qualified to be holding that position. I then went into private practice. I've been accepted as an NDIS client - sorry, NDIS therapist. My qualifications were seen as adequate for that, and I've worked for numerous EAP companies, again seeing my qualifications as enough. I work as a voluntary counsellor for refugees.

I really enjoy working in multi disciplinary ways, so maybe working with a psychiatrist, a school teacher, counsellors, other psychologists or social workers and lawyers, whatever is needed to best support my clients. A lot of my clients are actually psychologists or clinical psychologists as they come seeking relationship help. I am a supervisor for other therapists and I have recently spoken at two conferences, the Australia Pacific Rim Conference that was hosted by the Australian Counselling Association, and the ninth Stop Indigenous Domestic Violence Conference.

From my clients and my colleagues I get really good feedback. They invariably say about the therapeutic alliance that I develop. Well, they don't exactly use those terms, but they will say, 'Tess really got me. She was warm, she was welcoming, it was easy to talk with her.' They will say things like, 'I have never heard my husband talk about feelings like that in 23 years of marriage.' But this isn't rocket science, because we have known since 1979 about Gordon's Theory of therapeutic alliance being pivotal in efficacious therapy outcomes, and that's what my degree was excellent in preparing me for.

Most times I know what I'm doing, but I definitely love what I'm doing. I know I'm highly valued and respected by my clients and colleagues. What saddens me is that the majority of Australia cannot access my skills or resources because they can't pay a full fee because I cannot provide the medical health plan, and on top of that the absolute injustice they have to pay GST as well when they pay my full fee.

I have lots of people who might seek me out through EAP or through Google review who cannot maintain that therapeutic alliance which they've developed with me. I am, sounding rather egotistical, a wasted resource in Australia, especially when we see mental health escalating for the younger and the older populations. I know I'm not the only one. I know

there are hundreds, if not thousands of therapists highly qualified using best practice guidelines and therapies. We would really love to be able to offer to a broader demographic. I would love if we could take off the GST and we could add people with qualifications like mine specifically in counselling to the Medicare rebate scheme.

I can give you an example without breaching client confidentiality of how this is so relevant. Shall I continue?

MS ABRAMSON: Absolutely. I was making a note because I wanted to ask you about the GST.

MS REILLY-BROWNE: So I'm going to be really careful. So I've had a woman from rural Australia contact me. Her husband had just been released from hospital after two months for severe depression and anxiety. Their relationship was understandably really struggling. I offered them a 90 minute session, which we did, knowing that that's probably as far as their financial resources could go at that time, but they were really desperate and they still wanted it. This is via Zoom. Yes, you can still make a really great therapeutic link via video link.

So they were lucky in that that they had the resources for that one 90 minute session, but then they have to pay the GST on top of that, and this man after that 90 minute session texted me saying, 'I learnt more from that session than I've learnt from most therapies or therapists', and I was thinking he's talking about the two months that he's just been in hospital. He wasn't. This man had suffered terrible trauma in his childhood. That's why he had these complex diagnoses now. He was talking about a lifetime of therapy.

Now, this isn't about who I am as a therapist, this is about there are lots of other counsellors out there who also are very good at developing that therapeutic alliance that is pivotal, and also working in a multi disciplinary team. So, yes, that man and his wife are left high and dry for the moment.

MS ABRAMSON: Can we ask a couple of questions, and I may have got this wrong so I'm apologising in advance. Private health insurance, do any of the private health insurers cover counsellors?

MS REILLY-BROWNE: Yes. That's the actual final kicker for this couple. They then contacted me going - we knew they had insurance, I have a provider number with their specific company, which is a very small group of people, and yet that company was arguing, the last I heard, was arguing not to give them this small rebate, even though they have full cover, even though I have a provider number. So not unlike David's story when they're in an incredibly vulnerable difficult circumstance not only are they not getting supported by the scheme we have at the moment, but they're getting incredibly frustrated and their life's been made more difficult.

MS ABRAMSON: Thank you. One additional thing if I may, Harvey. I just want to ask you about the GST and my (indistinct words) get this wrong. I'm assuming that GST is payable because it's not a medical service, because I presume there's an exemption for medical services. That would seem - - -

MS REILLY-BROWNE: So, yes, but a psychologist wouldn't have to - but I would say I am practicing the same therapies the same way - - -

MS ABRAMSON: No, I understand the point.

MS REILLY-BROWNE: So, yes.

MS ABRAMSON: No, I understand.

MS REILLY-BROWNE: It's really inequitable.

MS ABRAMSON: I understand. Harvey?

PROF WHITEFORD: So we heard this morning from the Australian Counselling Association that there are about 5,000 members of the Association. This may be a question you don't have an answer to, but one issue in looking at remuneration for counselling would be to know within that 5,000 members who, with all due respect like you, and who might not be. So the quality control of that group and the consistency with which they would deliver evidence-based and effective counselling services.

MS REILLY-BROWNE: Okay. I can address that to a degree in that we must - to stay affiliated to the body, and I belong to the Australian Counselling Association, but I have belonged to PACFA as well - that we must have professional development every year, and we must have ongoing supervision, which not all other similar bodies do demand here. So I think in that way we've got some level of requirement, and supervisors have to be affiliated, so I have to have done training to be a supervisor.

So I would say it's as ethical as any body. That would be my experience, just having been at that conference where at least 500 people attended, the ACA conference. There's a high level of skill, but I think what really sets them apart is the ability to be with their client, to see the person, not the diagnosis, and invariably it will be me sharing with perhaps like David says a psychiatrist that hasn't had an hour and a half sitting with a client, or the lawyer who isn't trauma informed when there's a child welfare case.

PROF WHITEFORD: Thank you very much.

MS ABRAMSON: Thank you so much.

MS REILLY-BROWNE: Thank you.

MS ABRAMSON: And I understand, I'm looking at the staff at the back, that we do have somebody additional that wanted to make an appearance. Is that correct? Thank you, if you'd be kind enough to say who you are.

MS HANSEN-VELLA: Thank you for the opportunity to speak today without being on the listing previously. My name is Donna Hansen-Vella and I'm a mental health nurse of almost 30 years now. I have a background of working in clinical mental health services, both public and private. I also have 12 years working with the Australian Nursing Midwifery Federation

in this state, which I resigned from earlier this year. That role was predominantly within mental health services and been part of a negotiating team for the enterprise agreement, but also around implementing workforce innovations. At times I was also used by the Federation to be their representative on the national forums.

I'm not here today representing the views of the AMF, but just put that forward as part of sort of the context to my background. I also am a member of the Australian College of Mental Health Nurses who I understand have been specifically mentioned in some of the recommendations that are in the report.

I have sought to speak today in the context of some of the information that's been put forward today in the context of the workforce recommendation around 11.3, more specialist mental health nurses, and seek to actually contribute to that conversation. There are other elements of the report that I would seek to put forward and I will actually give a written submission as well, and thank you for the opportunity to be able to actually do that. That's an amazing opportunity that we have.

I also think it's important to put forward that I am the daughter of a mother with mental illness. So pretty much for most of my life have had that, and a stepmother too, a young woman with fairly severe mental illness.

So in terms of draft recommendation 11.3 I am a little bit concerned by the second dot point being in the medium term. I think it's too long. So I think that the work that the Productivity Commission has done has been very thorough in talking with a large range of stakeholders and actually getting to the nuts of our issue for my profession of mental health nursing, and that is that we are actually - a lot of people have used the terminology that the system is in crisis - as a profession we are actually in crisis.

There are a range of matters, and I think this is why I felt I wanted to talk today, because you had asked one of my colleagues some questions about why was it that you were hearing from some employers that they were having difficulty with recruitment, and yet we know that we have more nurses than we can actually take into graduate positions in the mental health sector, we knock them back.

So what I wanted to share with you is that my experience of that particular issue over the last 15 years, because I've had the opportunity to speak directly with most executive directors of nursing, health service organisations, State Government, around this - and members on the ground around this particular issue, or nurses on the ground, is that what the employers inevitably want from day one are mental health nurse to walk through their doors and be employed. That's not an option here in Australia. It hasn't been an option since the mid 90s. So I was probably one of the last people to go through the university-based training as a direct entry psychiatric nurse. I wanted to do it in hospitals, but it closed the year prior to me finishing HSC, so I had to do it through the university system. Now, that actually closed down that way of training in the mid 90s. So we then moved to comprehensive nursing.

That comprehensive nursing when it was under the state and territory regulation actually had some rules about what were the minimum requirements that needed to be provided in relation to mental health content. When we moved from the state and territory system to national

registration or regulation of our profession, as did the other health practitioners in 2010 I think it might have been, they did not uphold what we had in some of the states and Victoria was one of those, a requirement to have minimum requirements of mental health content in the curriculum.

So in actual fact what we have now is a comprehensive bachelor of nursing course that depending on what university you actually go to will actually influence what sort of mental health contents, and even what placement you get, and, you know, we have in Victoria some - and I'm mindful of not naming in today - but we have some really good university providers that have very passionate mental health nurses on their teaching curriculum and have managed against all odds - because there is stigma, there is still stigma about, you know, don't go into mental health, or do general before you actually decide to go into mental health.

I can even recall my own stigma when I was doing - because I did my general nursing after my mental health nursing and when I was a student of general nursing being told that once people discovered I was a psychiatric nurse, 'You only deal with the kind of - from the neck up stuff, you don't get your hands dirty.' Like that sort of stigma was real, and I have a niece who is currently - or two nieces actually doing their undergraduate training, both of whom tell me about similar stories on their placements, and also from within their teaching schools as well. So it is real that that actually happens, and I think it's not surprising because I think university and teaching situations are communities like we live in communities, and there is still stigma or fear in those communities.

But getting back to what happened we then lost our direct entry psychiatric nursing training. We then started moving towards comprehensive nursing training and it's now a bit of a choice by the universities as to how much content you have and how many placements somebody might have. We even have students that for their psychiatric placement get counted going to a nursing home as their psychiatric placement. Now, clearly there are residents in the nursing homes that actually have significant mental health needs, but I wouldn't - as a mental health nurse I wouldn't classify the nursing home as a psychiatric placement for an undergraduate student. So it is this incredible amount of diversity about not just their academic preparation but their placements.

As I said there are universities who are doing a really, really good job and they're the students that in my current position as a senior psychiatric nurse that I want to employ, because I know that they've had the right amount of, or at least a better amount of undergraduate academic preparation and also clinical placements. They aren't though from day one on the whole in the sector considered a mental health nurse.

Now, what they need to do to become a mental health nurse, and we are very, very strong on this in Victoria both professionally and industrially is jump a few more hurdles. So, you know, they've come out of their three year comprehensive training, they have their university debt, and they come into employment on day one. Inevitably they're not given a permanent position. We have two area mental health services that will now give them - because they've had to address the gap in vacancies, but everyone else is still putting them on a fixed term position.

So when you've got an option to walk into another specialisation in the hospital in a permanent position from day one versus you're still passionate about mental health, but you need to come in and enter into a fixed term contract for two years, both on 12 months, so you have to be interviewed, get that job, you're given a 12 month fixed term position to be a graduate nurse in mental health. You then have to reapply, be re-interviewed and hope that you're successful in getting the next 12 months position in your postgraduate. It's a funnel.

So the amount of graduate nurses that we can take into mental health is around 190 at the moment in our state, but the amount of postgraduate nurses that we can take is less. I understand it's around 110, it depends which data you read. So, you know, we already are narrowing our intake of our new workforce. Once again as I said they're not considered a mental health nurse. So the first two years commitment to practicing with your mental health and coming with, you know, in secure employment they're still not considered a mental health nurse amongst everybody that they're actually working with. We don't apply that bar to our allied health colleagues. Our allied health colleagues as my colleague from the Health and Community Services Union mentioned can when they've done a little bit of time somewhere else, child protection, can apply and be appointed to a position within say the community mental health team, and they're not questioned about their experience and they're given a permanent position. But we don't have that option for nurses within this state.

My other colleague Andrew Morgan talked about the potential for an internship. We've actually had that option available industrially for the last seven years in this state. Our employers are not using it, and they're not using it because of their concerns or I guess part of the culture that that person still isn't a mental health nurse. So we actually have some very major employers going over to the UK depleting their system, that's my personal view, of their mental health nurses and bringing them back here and then having to do enormous effort at helping them to acclimatise to not only working within the Australian mental health system, but also just acclimatising to living in our community.

So inevitably I'm making a plea if recommendation 11.3 could be considered to be shortened. In terms of the steps that you've outlined there it's already known, it's known what the curriculum is. My colleague Michael Blair earlier this morning mentioned Professor Brenda Happell who is well known regarded academically, received significant awards for her leadership with relation to academic and inclusion of consumer workforce within co-teaching of the curricular, has already got the curriculum. I suggest that she probably needs to update the curriculum in comparison with Charles Sturt University's course that they deliver for indigenous mental healthcare workforce. Fabulous, I wish that we actually had that available for nurses. Even though it's delivered through their nursing and midwifery department it's not available for nurses as such in terms of it being a nursing course. So, you know, that sort of stuff can happen very quickly, it doesn't take up to two years.

You've suggested in the medium term specialist registration. Well, that was already discussed and debated back in 2010, and in fact there was recognition that the law for regulating health practitioners already actually enables for recognition of specialisation. It's how doctors are able to do it, it's how psychologists are able to do it. It's even how some forms of dentals can actually do it. It's there and it's available, it shouldn't take two to five years. I think that that's waiting too long.

The second thing that I wanted to talk to was just around - a lot of the recommendations, which I really welcome around the step model, probably haven't picked up on the issue for my profession as a mental health nurse, and that issue is that the kind of stuff from around really step 3, around that sort of access to focus psychological therapy, mental health nurses are now excluded from being providers of that. So we used to be eligible to be providers of that under what was known as MHNIP, so mental health nursing incentive program funding. It was the Commonwealth funding. (Indistinct) that actually enabled an eligible organisation. Inevitably it was meant to be the doctor or the psychiatrist that could actually employ mental health nurses.

Now, this program, Commonwealth funded program, has been evaluated on at least two occasions. One of those was actually funded by the Commonwealth when they actually were needing to evaluate it, and provided the actual - which goes to the heart of the Productivity Commission - provided the evidence about not only its effectiveness in terms of client outcomes and outcomes for families, but also the cost effectiveness of that program, and unfortunately that program was frozen by the Commonwealth and then has actually been absorbed into the primary healthcare networks. So there's actually no requirement - firstly, it doesn't exist anymore, there's not a mental health nurse incentive program any more. So our communities do not have access to mental health nurses in the community unless they're actually managing to get to see, which you've heard a lot about the hurdles they need to jump through to get to see someone who's employed in a public health service or someone working within private practice, and those people who try to set up their own private practice who are nurses, mental health nurses, inevitably struggle because they don't have access to the MBS item. So I just encourage you to consider whether you would extend those recommendations to have something specific to the disciplines who do not actually have access to MBS items, because inevitably they're sound recommendations, but they exclude mental health nurses by the fact that they are not eligible for MBS, to be an MBS provider of those items.

MS ABRAMSON: I understand that. Harvey?

PROF WHITEFORD: No, you've said it all.

MS ABRAMSON: Every time I thought we were going to ask a question you answered it.

MS HANSEN-VELLA: And I just - just the very final thing, and, sorry, I am very mindful of the time and thank you for allowing me to speak without prior notice, is around that, the earlier conversation about the sort of proportion of direct care that somebody might actually be able to provide somebody. So within Victoria in the industrial instrument there's actually regulation of that, and the regulation is what we call a 60/40 system. So all of our community mental health clinicians employed in the public sector have a community workload management system. I think it's actually Dr King was in his earlier career employed by the state to actually evaluate what was in the old psychiatric employment agreement and never implemented. Even though it was an EBA requirement only two out of the health services did it, and he did a lot of research in looking at models at that point in time.

We then took his work, so I just want to recognise in his absence the amazing work he did in that space, took his work a step further to actually require regulation of that, and how that was done was by mapping the work that was happening in public community mental health

services. Now, in public community health services there's this layer of administrative stuff which is kind of covering risk that goes on. So once we mapped all of that it actually turned out that 40 per cent of the community clinicians time needed to be quarantined for what's industrially described as organisational duties and functions, and the other 60 per cent of their working time is available for direct care. That direct care does also include secondary consultation, all those sort of duties. So that's probably one of the I guess most advanced pieces of work that I'm aware of in our country that's actually done that mapping out.

PROF WHITEFORD: Have you got - do you know where we get - - -

MS HANSEN-VELLA: I'm happy to provide that to - - -

PROF WHITEFORD: That would be great, thank you.

MS HANSEN-VELLA: - - - to the Commission. So it's public in terms of the enterprise agreement.

PROF WHITEFORD: That would be great, thanks.

MS HANSEN-VELLA: But otherwise, yes, unless you've got any questions about that work.

MS ABRAMSON: No, no, it's been fantastic, and in your written submission which you've been kind enough to say you will do really interested in that diagrammatic thing you talked about the funnelling of graduates, and actually it's that practical type stuff we're really interested in, but thank you for appearing today.

MS HANSEN-VELLA: And thank you, thank you for the opportunity.

PROF WHITEFORD: Thanks, Donna.

MS ABRAMSON: And we have one other person. Thank you. If you'd be kind enough to announce your name for the record and the capacity in which you appear.

MS MULLEN: Thank you. Thank you very much. My name is Barb Mullen, I'm the founding chairperson of BPD Community; that's Borderline Personality Disorder Community, and I would like to thank you for your report and make a strong point how we value the work that you have done.

BPD Community has existed since 2015. It's a grassroots peer led organisation. It's an independent organisation, it's a charity for right. Personally I myself am a carer. We are a charity for people with BPD, their families and friends and those who work with us, particularly those who work in the community sector of which there are not that many more here in Victoria. We have no funding, we have no staff, we have no infrastructure, yet we've offered services and programs that do make a difference and we are told how much they make a difference and we've done that since 2015.

I want to make a couple of points because I'm unsure as to what particularly address and so I want to leave it open if you do have any questions, otherwise it's very short and simple. I want to make a point about stigma and discrimination. In relation to BPD from the work that we have done and the studies that we have done and the research that we have done, or the research that we have read the stigma and discrimination emanates from within our mental health system and our mental health professions in spite of the best intentions of all of the good people who work in there.

I would like to make the point that anecdotally less than 2 per cent of people in Victoria are treated in a year; 2 per cent of people with BPD are treated within a year. That's based on an anecdotal estimate given to me, about 4,000 people a year being treated, and that's based on the American accepted prevalence figure of 5.9 per cent equating to approximately 350 people here in Victoria who would need a diagnosis of BPD.

The sad thing is that recovery from BPD is a realistic possibility. Recovery has got three components we believe; treatment, social and relational supports. I'll talk a bit more about that in a second, but I want to make the point that we know that when we're in a privileged position that we fail to see the privilege that we're in, and I want to make the point that the medical model is privileged within the mental health system, and therein lies a big dilemma for us, and I humbly suggest that when the medical model of treatment supports is privileged then social and relational supports are seen as an adjunct, as an extra, whereas the clinician and the treatment is seen as the central thing.

We see those three components as equal partners, and that treatments, social and relational supports together can lead towards recovery, and that perhaps treatment is not necessarily essential, but social and relational supports are. Currently in Victoria the medical model is privileged, and the interim report sadly doesn't inspire confidence in me that this will change.

I wanted to make the point about relational supports to explain that just a little bit further. With BPD we take the simple - with BPD Community I'm sorry - we take the simple explanation of BPD as having five areas or five domains of dysregulation; emotional dysregulation, behavioural dysregulation, relational dysregulation, cognitive dysregulation and identity dysregulation, and we choose that simple approach in order to understand the enormous complexity that BPD can present.

Relational dysregulation is a really important aspect, because it places families in extraordinary trauma, and we know that people with BPD may have - there are all sorts of ways of explaining it, to explain the relational dysregulation, and one common theory is attachment theory, but relational dysregulation is really traumatic for the person with BDP. But the effect on that within the family is extremely severe, and yet it is families who are the ones that are often carrying the burden of support for their loved ones. So I want to make that very, very strong point about relational dysregulation or relational support, as well as support for employment; legal support as mentioned earlier with the example from St Kilda, and budgeting support, other sorts of things like art therapies, even something as simple as singing, a whole complex way that you can engage people in community to help them ultimately achieve their potential aside from the demands of treatment and the clinical environment.

I would like to leave that there, because that's short and simple, and then if you have questions please I'd be very happy to answer them.

MS ABRAMSON: No, that's been very helpful. Harvey?

PROF WHITEFORD: So just one question quickly. With the support network when you say what's lacking is I guess the social and relation component, or when funding is tight or time is tight they seem to drop off first if they were there to start with. Is that because the clinicians the members of the community have seen don't recognise it, or that isn't available for the consumers to access?

MS MULLEN: I think it's both those things and I think it's also more complex. I made the point about 2 per cent of people with BPD get treatment, and so the people that we see in our community many of them don't get treatment at all. Many people don't get a diagnosis.

PROF WHITEFORD: They don't get clinical treatment even?

MS MULLEN: Don't get clinical treatment. Two per cent approximately get treatment. They don't get diagnoses, and as was made, the point was made earlier that with a diagnosis then you've got access to Google. You know, you can find things out, you can find out and you can learn the techniques, because the sad thing is BPD is a condition for which complete recovery is possible, and there are techniques that families and friends can learn that can support their loved ones as well as themselves, and all of that is within range except 2 per cent approximately a year get treatment. Of those some of them don't even get diagnoses. Then there is some, well over 90 per cent of people who have a need for things, for supports, but they're not getting them. So if you look at in a clinical environment it's the medical model that dominates, and so when I make that point about privilege when the medical dominates that's what they see. They don't see those supports as being important.

PROF WHITEFORD: Critical. No, I understand. Thank you for clarifying.

MS ABRAMSON: I have two questions. The 2 per cent that you've been talking to us about where is that based on, is it a survey or - - -

MS MULLEN: It was anecdotal. So I asked an eminent leading psychiatrist in the BPD Community and the BPD world here in Victoria and his estimate was based on his own organisation and what he knew, that it was approximately 4,000 a year who were in treatment. I don't know if there are any figures anywhere as to what there is - I'm not sure, in his own service at the time I think it was about 400 a year were being treated with BPD. So it's an estimate.

You could take a prevalence of 4 per cent, an d that would still give you under 2 per cent getting treatment. And there are arguments about what the prevalence of BPD is as well, because the data used here is based from 1980, I believe, the last time there was prevalence data on BPD in Australia.

You'd know that if you look at some of the data that's collected, the national data that's collected, we will have data on bipolar, we'll have data on schizophrenia; there is no specific

data on BPD, in spite of its prevalence, in spite it's a serious and complex mental illness, and the effects that it has in not being treated.

MS ABRAMSON: I have one further question. We've got our recommendation about encouraging interaction between mental health professionals and people with lived experience, away from the healthcare model, and on an equal footing. Do you think that that would help address the stigma issues that you've been talking about? And you know, your comments about the privilege model.

MS MULLEN: My experience is that peer workers within the system in Victoria are constrained within the system that they work. I'm personally very harsh and critical and I see the medical model as patronising, as hierarchical in structure. And that those wonderful people with extraordinary experience and news don't see quite the importance or the significance of what I would call social support and relational support.

And I am loathe to speak more to that, because I am loathe to.

MS ABRAMSON: No, no, I understand.

MS MULLEN: So I don't see it happening now. I think that our system is broken; I think we need a paradigm shift in thinking; I think that the shift in thinking we need to do. And the reason I am speaking now is because of earlier I heard people trying to explain about the medical model and how it was a constraint, and trying to communicate that concept and why that is seen to be so, by - I referred to Marie Piu from Tandem, and prior to that, from Mind - trying to talk to that, and finding it difficult to explain, which is why I've tried to do it with this reference to privileging and seeing it from that particular perspective.

So I'm not confident that it will change. Stigma discrimination would change, in particular with education within the mental health professions and the mental health workforce; it would change when BPD is able to be counted as a distinct disorder amongst the data; it would change when there is research done into such stuff as prevalence; it would change when we stop arguing about what the name of the disorder is.

It's often described to me that in Victoria in particular, we are dealing with a famine mentality for funding, and so it would change when mental health organisations are able to work collaboratively together, without having to be worried about where their next lot of funding is coming from. It's from all sorts of sources.

MS ABRAMSON: Thank you. Harvey?

PROF WHITEFORD: No, that's fine. Thank you.

MS ABRAMSON: Thank you so much.

PROF WHITEFORD: Thanks very much.

MS ABRAMSON: Thank you.

MS MULLEN: Thank you.

MS ABRAMSON: I can now adjourn the proceedings for the day, and we're reconvening 8.30 tomorrow. And thank you very much for your attendance today.

MATTER ADJOURNED UNTIL
TUESDAY 19 NOVEMBER 2019