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PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

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MS JULIE ABRAMSON, COMMISSIONER
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TRANSCRIPT OF PROCEEDINGS

AT THE GERALDTON CLUB, 160 MARINE TERRACE, GERALDTON
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PROF KING: All right, let's get started, folks. Good morning all, welcome to the public hearings for the Productivity Commission's inquiry into improving mental health in Australia. My name is Stephen King and I'm the presiding commissioner on this inquiry. With me up here I have An Tran, Alistair Davidson is at the back, and on the phone, we have Commissioner Julie Abramson.

Before we begin today's proceedings, I would like to acknowledge the Southern Yamatji peoples for the traditional owners and first people of these lands. They are Nhanhagardi, Wilunyu and Amangu. I would like to pay my respects to elders, past, present and emerging, for they hold the memories, the traditions, the culture and the hopes of the Southern Yamatji peoples. I extend this respect to all Aboriginal and Torres Strait Islander peoples in attendance today.

The purpose of this round of hearings is to facilitate public scrutiny of the Commission's work and to receive feedback and comments on the draft report. This hearing in Geraldton is one of many around Australia in all states and territories and the capital cities and regional areas.

We will then be working towards completing a final report to government in May, when we've considered all the evidence presented at the hearings and in submissions, as well as other formal discussions. Submissions and comments to the inquiry will close on 23 January. Participants and those who have registered their interest in the inquiry will be automatically advised of the final reports released by government, which may be up to 25 parliamentary sitting days after completion.

We will conduct all hearings in a reasonably informal manner, but I would like to remind participants that there are clear structures in our legislation for how these hearings are legally backed, and a full transcript is being taken. For this reason, we cannot take comments from the floor, but I will allow time at the end of today's hearings, or otherwise during the hearings, depending on the schedule, if anyone who hasn't formally registered to speak wishes to speak. If you wish to do so, by the way, have a chat, probably with Alistair down the back at some stage, so we can pop you into the schedule.

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

You are all free to enter and exit the room as you want, and if anyone needs a quiet space, please feel free to exit the hearing; there is a quiet space outside on the balcony out the back. If, at any time, you feel distressed, please approach one of our staff, who will assist you. We also have Leanne Prirottina, who's just had her hand up; a clinical psychologist from 360 Health + Community, who is available to provide support if need be.

In the unlikely event of an emergency requiring evacuation of this building, please head out the back door, across the balcony and down the stairs to the carpark. And toilets are located out this door that you came in, to the left, down the corridor; I assume that means that way.

Yes, that way and down the corridor. If you require assistance, please speak to one of our inquiry team members here today, so An and Alistair.

Our first participant today is going to be a representative from HelpingMinds, and I invite them to come up, join us at the table. And just for the transcript, if you can state your name, your organisation, and any opening comments that you'd like to make.

MS CHILDS: Okay, thank you. My name is Deborah Childs and I'm the Chief Executive Officer of HelpingMinds.

HelpingMinds is a not for profit mental health and carer support provider, delivering services across WA and Darwin, for both adults and children. We started as a ARAFMI, the Association for the Relatives and Friends of the Mentally Ill, over 43 years ago, and we understand that having a loved one who is experiencing mental ill-health can be a difficult and isolating experience.

HelpingMinds has 11 offices throughout WA and one in Darwin, and a team of over a hundred team members to provide support. We have a diverse group of team members from many cultural backgrounds, and over 75 per cent of our team have either their own lived experience of mental ill-health, or lived experience as a mental health carer.

We offer a range of social, emotional and practical supports, that is, psychosocial supports, and that help individuals, families and friends, and carers cope, during stressful times. And we work directly with families and friends to assist them in sustaining their ongoing caring role, and also work with individuals who require support as a result of a mental health issue.

I can go into greater detail and I will; we will provide a written submission, so to keep it concise: to help deliver wraparound supports, we partner with a number of clinical services, both community mental health headspaces and in-patient mental health units in WA. And in the last 12 months, we've engaged with over 25,000 people throughout WA and the Northern Territory.

According to the ABS, the number of family members and friends in WA providing care to a person with a disability due to a psychosocial condition has been estimated to be around 61,000; however, academic research has suggested this figure is a considerable underestimate. And approximately 15 per cent of all Australian adults are providing care or support to a family member with a mental health issue. And there are many young people, including children, who are also in an ongoing caring role for their parents and other family members living with a mental illness or, using the NDIS vernacular, psychosocial disability.

HelpingMinds welcomes the Productivity Commission's draft report, and feels it is an excellent opportunity to re-evaluate Australia's mental health service system, beyond the medical and clinical framing of mental illness and medical interventions. We also intend to provide a written submission prior to 23 January 2020.

We feel the report is heading in the right direction, and offers welcome reforms to the mental health system. HelpingMinds also supports the submissions of both Mental Health Australia

and Mental Health Carers Australia, and we also support the Time to Fix Mental Health campaign with Mental Health Australia.

The insights that we'd like to offer to the draft report come under two broad headings; the first heading is a rather long heading: "Carers, Families, Friends and Young People." And the second is, "Workforce." So, I'll start with the second, the workforce.

Overall, this draft report is structured around the service planning framework, which highlights the clinical and biomedical, and we feel misses the understanding and need for psychosocial supports, in being an holistic part of mental health recovery.

There needs to be recognition of the need to balance the system, both clinically and in a community mental health setting. There is significant cost in hospital stays, both financially, emotionally, and traumatically. Community mental health focuses on in-community support, so that allows a recovery and relational approach.

In our opinion, the final report needs to provide a greater emphasis on the relational-based approach to recovery for all Australians who are affected by mental ill-health. The final report needs to provide a greater focus on social and emotional wellbeing for everyone living in Australia, and more focused on the social and economic determinants of health, to ensure ongoing recovery.

It is our recommendation that the Productivity Commission looks at the workforce through a lens of relational recovery and citizenship, therefore addressing the social determinants, as much of this is emotional support and therefore mitigating the fallouts of some of the ineffective systems that are currently in place, that don't currently work with psychosocial supports.

We recommend utilising the community managed sector in partnership with government, clinical and medical services, embedding a collaborative model so that community mental health employees are entrenched within the services; an example of this successfully working in WA is the collaboration HelpingMinds has with the headspace providers throughout WA, which supports family members when a young person is having support through the headspace. Separately, at Royal Perth Hospital Community Mental Health Unit, we provide psychosocial supports alongside the clinical and medical interventions.

We also endorse that there is a need for greater investment in recovery colleges and integrated employment services, including for family and carers. These allow self-empowerment in recovery; they can assist with resources, rights, roles, relationships, and responsibilities people need to regain their citizenship, including their family members.

A current example is the Broome Recovery College in Broome; this is a collaborative community model, with community mental health and non-government agencies such as HelpingMinds, working together to provide an alternative and additional support to traditional mental health supports. It is an educative and empowering model providing immediate benefit to the Broome community, when it rolled-out over 12 months ago.

The draft report has gone into detail on some workforce issues, and we seek further recommendation to address the challenges of recruiting and retaining specialised mental health community support workers. This has always been an issue in regional and remote areas, and now, with the changing individualised funding, is proving an issue in central areas like Darwin and Perth.

We welcome the recommendation to strengthen the community health and consumer carer/peer workforce, and see this as a positive step forward in the provision of recovery-focused mental healthcare. However, as mentioned previously, we see a significant gap in the report in relation to community-managed organisations' workforces.

The current community-managed workforces, as I mentioned, faces significant challenges, and HelpingMinds, as an employer, is facing increasing difficulties in the recruitment and retention of suitably trained staff; this is particularly highlighted at the moment in the regional and remote areas of WA such as the Gascoyne and Pilbara. In addition, we feel a more formal recognition of the importance of consumer and carer/peer workforce is required, along with a framework to guide employers, as happens with other roles such as counselling and psychology.

With regard to psychosocial supports, people do ask for face-to-face supports in regional areas, however, online supports do allow confidentiality in small communities, so people aren't going into an office to have a session. However, that does require reliable access to the Internet, and also, we found that in small communities there is not necessarily the understanding or the technology available to do this at all times. We do find that a relational approach with an in-person support worker is most effective.

We certainly welcome the recommendation to lengthen community-managed contracts to five years. Our ask for the workforce area is recognition of the importance of community-managed workforce in providing psychosocial supports in recovery, and within our written submission I will go into more detail, but I don't want to take up time today.

Throughout the report, we call for increased focus and investment in integrated services where clinical and psychological supports are delivered in partnership between public and private, government and non-government mental health systems, and more investment in a dedicated carer and family workforce. And finally under workforce, development of a national co-production framework to guide how families and carers can work in partnership with the government and non-government sector.

The second topic is carer and family inclusion. So HelpingMinds supports the recommendations related to carer income support and the 25-hour rule. The dedicated family and carer chapter in the detailed report captures many key family and carer challenges and opportunities well, however, we didn't feel they generally translated through the recommendations and reforms. We'd like to see family and carer element integrated throughout the report, rather than as an add-on.

We'd like to ensure that families and carers are also involved in all aspects of service design, with a true co-design approach needing to be undertaken at all levels of mental health supports, whether clinical, medical, or psychosocial. To that end, mental health carers have

expressed to us their disappointment in the loss of mental health respite carer support funding program through the Department of Social Services.

Respite is essential for carers to maintain their caring role in a sustainable manner. The integrated carer support service - this is the new online service through the Department of Social Services - is a good concept, however, as a consortium partner to deliver the IDP in Western Australia, our financial modelling shows the amount of services available through the allocated funding will not provide sufficient services to mental health carers, as and when required.

Also, the ICSS program is for all carers, and mental health caring does differ from aged caring and physical caring. In addition, it is vital that mental health carer services are not lost due to the introduction of the ICSS at a federal level. Should state funding be lost, a significant gap will emerge for people in a mental health caring support role.

Our next point is with regards to clinicians, GPs, psychiatrists, mental health nurses, and how they engage with families and carers of their patients. We feel a change in culture in mental health services, where the hospital or community and NGOs is needed, in respect to carer and family engagement. This can be achieved by the final report recommending - or preferably mandating - this cultural shift to carer-inclusive practice be included within quality and safety standards.

We have a co-design tool - which I have brought copies of to leave with you - to assist in the implementation of a change of cultural practice to carer-inclusive practice. The practical guide for working with carers of people with a mental illness was a major co-design project between five not-for-profits throughout Australia, and it used a true co-design model: it utilises the triangle of care to ensure effective communication between the consumer, carer and clinician.

From a lived experience perspective, this would benefit all involved; from my own lived experience, there is nothing worse than being called as a carer to collect your loved one that has been discharged from hospital, and when you ask, "What medication regime, what do I need to do?" and you're told, "They just need somewhere to go, they just need somewhere to stay. Don't worry about it, we've told them all about the medication," and then a few days later, they are suicidal again, that doesn't resolve anything. And going around in circles.

People are being discharged in some cases - and I'm not saying in all case - but in some cases, without due care. And if there aren't carers at home, such as myself, that can lead to homelessness, an interaction with the justice system, and in the worst outcome, it could be the untimely death of that individual. And from a personal experience, you know, something needs to be done.

Therefore, HelpingMinds and myself, as a mental health carer, recommend to you that serious attention be paid to the practical guide as it can effectively provide a mechanism to allow for cultural change that is required around family and carer engagement, resulting in better outcomes for everybody involved. We also recommend a recommendation around strengthening the Carer Recognition Act.

We've got a brief comment regarding wellbeing leaders in schools. So we welcome this initiative, but do wonder if it would be better embedding a wellbeing specialist from a community-managed organisation, as this would allow for better collaboration and integration between the educational settings and the community. It would also allow students to seek supports outside of school hours, and allow teachers to focus on their core remit of education.

Teachers are already stretched in their role, so why don't we play to people's strengths and provide qualified mental health professionals to provide this early intervention wellbeing supports to schools?

In effect, there is a Department of Social Services funding currently for early intervention supports for young people at risk of developing a mental health issue; HelpingMinds runs these programs in Kununurra, through the Kimberley and through the Gascoyne, midwest and Perth, and the Swan. So children that are identified at risk, we're able to work with; if that was opened up to the general population of the school - that's a similar initiative - it would probably be very effective because we found great effects in the service that we've been providing that way for the last six years.

So our ask, in the area of carer, families, and young people is, we believe a cultural shift to carer-inclusive practice must be informed in every setting, whether clinical or community-managed, and by implementing or utilising the practical guide for working with carers of people with a mental illness. Without our written submission, we will make a recommendation for a change or addition to draft recommendation 13.3; so we'll provide that.

The second request is the development and application of a national co-production framework. There needs to be more attention to the involvement of families and carers in all aspects of system design. And thirdly, the missing family and carer voice is a critical component to a new reformed system. We call for all family and carer voices to not only be heard, but systematically seen and included in services and recommendations throughout the report.

In finishing, I would like to add that one of my favourite sayings is from Einstein: "If you always do what you've always done, you'll always get what you've always got." This Productivity Commission gives Australia the opportunity to review what we've been doing and look for ways to improve, so that every person living in Australia has the ability to live a good life, with the supports needed, as and when they need them.

We need to remember that Australia is large and diverse, and what works in Canberra or even Perth will not necessarily work in regional and remote WA. We acknowledge the recommendations for regional commissioning, however, are slightly concerned how this would integrate with federal, state and PHN commissioning, and we need to ensure that another level of complication is not added to an already crowded commissioning space. Streamlining federal and state funding with fewer points to place blame would, in our opinion, be optimal.

HelpingMinds appreciates this opportunity to provide the oral submission today, and I'd like to end by thanking the Commissioners for the draft report, and we really look forward to seeing the final report in May.

PROF KING: Thank you very much, Ms Childs.

MS CHILDS: Thank you.

PROF KING: Let me lead off the questioning. One of the issues you raised - and it has caused us some discussion internally - which is around where consumers, carers, the network, the support network that individuals need to be able to stabilise to recover from mental illness. And the reason why we've had this discussion is that it is a balancing act, in the sense that we want consumer-centred care, recognising consumers need support, and recognising that there's a risk of when you say, "Well, the support becomes the centre, so you end up with the consumer and carer-centred system," that you actually disempower the consumers.

And that is a discussion that we've heard from others, and we've also discussed ourselves. So in our draft report, we were very careful; we said, "The consumer is the centre, it's consumer co-design, it's consumer input, with the assistance of the support network." But it is not, I think to use your words, you said "a consumer and carer co-design." And so we've been quite explicitly saying, "That's not the right way." Now, that's obviously against what you view.

MS CHILDS: Yes.

PROF KING: So please push back on. Why isn't carer co-design, why isn't that disempowering to consumers?

MS CHILDS: In my opinion, and with lived experience as a carer, I would suggest that every person is not an island, and so we need to - utilising an holistic approach with consumers and families, and a wraparound support working together, would provide better outcomes. I mean, I'm well aware of the debate between, you know, there's the consumer movement and the carer movement; I appreciate that.

And maybe I am naïve in my thoughts, but I think it would be really good for people to actually work together and provide supports together. When carers are excluded from care, they are at a higher risk of developing their own mental health issues, so then that could exacerbate the need for more mental health supports as well. So by working together - and it may not be right for each and every situation, and you know, you can't have broad brushstrokes; you actually need to look at situations and make recommendations on what suits a particular area or a particular cohort of people.

PROF KING: Okay. I think you're exactly right by the way, when you say it depends on the situation, because we have heard from consumers who have said, you know, "I wanted my carers, specific people, to receive the information but it seems that that's impossible." But we've also heard from consumers who have said, "Well, I actually don't want this person getting the information," you know, they're feeling disempowered because of the relationship with the person who considers themselves their carer.

MS CHILDS: Yes, yes.

PROF KING: Sometimes, then the consumer doesn't quite see it that way.

MS CHILDS: That's it, yes, yes.

PROF KING: So how do we get the flexibility in the system to make it that - again, it comes back to the consumer-centred element: how do we get the flexibilities of the consumer is able to say, "Yes, I want this, this is my carer, this is the person," you know, "Treat them as me," in the sense of the information flows and so on, versus the other situation? Particularly when consumers are often vulnerable.

MS CHILDS: Yes. So I would say when there is a first contact with a consumer, say within a clinical service, ask them if they have a carer or family member that looks after them or supports them, or works with them; if they say, "No, I don't want anybody involved," at that stage, ask again the next day. Keep asking that question, because that then allows them the consumer to have the ability to decide if they want family or carers involved. Don't ask once and then not ask, and if it's an outright no, don't ask again.

Also, from a carer's perspective, you don't have to talk about that particular consumer or that particular patient; it can be generic, it can be around you know, "Well, here's some information around Borderline Personality. Here's some information about services that may help you in this situation."

PROF KING: Yes.

MS CHILDS: There is some really good education courses that carers can be directed to as well, so it doesn't need to necessarily be an either/or; it can be, "Okay, this is where the consumer is at today." And I do understand from a carer role: a person that I care for on some days would be more than happy for me to have every bit of information, and want me to have every bit of information; on other days, they won't. But you need to keep asking that question, and that's where these standards within the practice come.

PROF KING: So keep asking that question on both sides?

MS CHILDS: Yes.

PROF KING: So it may be the situation, you know, you've said you want to share your information with this person, do you want this - and they have the right to say no?

MS CHILDS: They have the right to say no. It needs to be understanding on both sides as well. Yes, from a carer point of view there's generic information that you can find out. I do think though when people are being discharged from hospital it is fair enough to have a good understanding of what is expected of you within that caring role, and by utilising the triangle of care and having that three way communication, so it's not communication between the carer and the consumer and then the consumer and the clinician, it's actually let's all talk together. Providing that both - all parties are happy to do that that would be the recommendation that we found the best.

PROF KING: One of the things to in a sense enable that what we have been thinking about, and it's not in the draft report, so it's not obviously draft report as a point in time, we're still thinking and our thinking has progressed since the draft report, but it does relate to consumers and particularly the clinical data but not just the clinical data, and making it quite explicit that the consumers have rights over that data and can share that data. Do you think that would go part of a way to helping both empower the consumers and keep the carers in a loop in a sense rather than it being the case of, well the carer has to hope the clinician has a chat with them and invites them in afterwards. No, no, it's the consumer who says this person gets - 'When I'm given a script this person needs to be notified of exactly what the script is, the medicine and so on, that's my health data.' So we're sort of trying to think about how to make those lines of communication clear and consumer centred.

MS CHILDS: Yes. I think it's an interesting dynamic and it does - I think we need to - you know, we acknowledge it changes.

PROF KING: It does change, yes.

MS CHILDS: So asking that question on an ongoing basis, and trying to - I think it is - it is about good communication, and at the start of a discussion or when intake forms are being filled in it could be as simple as, 'Do you have a carer?' 'No, I don't want anybody to know.' 'Do you have anybody that you deal with on a daily basis that we could have their name and address?' And then the next day it can be, you know, 'Yesterday you said you don't have anyone that cares for you. Is there anybody that you would like to have this information that might be able to help?'

PROF KING: Yes. It may not be a carer, you may not think of them as a carer, but is there somebody who you would like to - who assists you with your medication for example.

MS CHILDS: Yes, or assists you in day to day, or is there somebody that you call regularly when you need help, something - yes.

PROF KING: And then what would you like to share with them.

MS CHILDS: Yes, what would you like to share, yes. I'm not saying it should be compulsory that everything is shared (indistinct), no.

PROF KING: No. But it is getting that dialogue and in getting that balance right. And I think it would take a bit to move (indistinct) consumer centred in our approach, but we want to make sure that we're not locking out other really important groups by saying the consumer centre - at the end it's about empowering consumer and the outcomes for the consumer, recognising that needs a network.

MS CHILDS: Yes, it does need a network and wraparound, yes.

PROF KING: Young carers are wanted. I'm going to ask a series of questions and then I will pass over to Julie and then I will check if An has any questions. Young carers: young carers really concern me. We didn't go into a lot of detail on young carers, and I will confess

that my immediate reaction is that - I can't put my finger on it and I don't think the teams have put their finger on it, but something seems wrong in the system where you're putting so much onus on a young person who themselves are very vulnerable, are trying to get their education, get their life in order, at the same time we're saying that person can be caring for say a parent. That really worries me, so I'd be very interested in your thoughts about young carers, because I don't think we have any recommendations explicitly to young carers. Should we? Are we missing something we can recommend there?

MS CHILDS: I think a recommendation within schools to identify young carers. So is there a child within your class who's coming in and falling asleep, is being disruptive, you know, and what is the reason behind that, because I'm well aware of 5 and 6 year old and 7 year old children who are getting up making mum a cup of tea and giving her medication. They're making sandwiches and getting themselves to school. Obviously that impacts on their day to day, but they don't know - what they don't know - they don't know that it's different.

PROF KING: That's right. For them this is normal.

MS CHILDS: Yes, but it's different from anybody else. So I think early identification within the NDIS and psychosocial support teams that we have every time a team member is going - we go in to do an intake process we identify who is around - you know, are the young children in the house, are other people, family members within the house, and look at are the needs - are the supports available for example. The early intervention program is about identifying children at risk and young carers do face a greater risk of developing their own mental health issue in the longer term.

PROF KING: I don't think I have asked this. I was about to say I should know the answer to this, but I'm not sure I should because I'm not sure whether it's been asked, but when a consumer identifies a carer and it is a child do they identify the carer - because I was thinking what you mentioned before where, okay, let's have that conversation, let's make sure the carers are identified, they're brought in the loop where the consumer wants them to be. I mean that also is a way of then saying now we have a record of who the carer is. It's a child who's attending this school. I am reluctant to say the school should be notified because it's really the consumer's data, but that situation you are dealing with a minor and I think, yes, the school needs to know. But is there any issue, do consumers identify young carers?

MS CHILDS: I think in the experience we've had personally, but also what I've seen through Arafmi and HelpingMinds particularly, carer identification is really difficult. I didn't realise I was a mental health carer until I started the role with Arafmi. Stigma - that's a whole other ballgame - but stigma, I was brought up with do not talk about mental - do not talk about this person, we don't talk about this person because you don't. So I think the issue is carer identification, and I think it's a really interesting thought around - and I don't have an answer, I need to think about this more - around do parents realise that their young person that they are - their child - - -

PROF KING: Helps them with their medication, gets the breakfast for the other kids.

MS CHILDS: That is actually a caring support role - you know, who's the parent, who's the child sort of roles. Yes.

PROF KING: You mentioned that mental health caring differs from other forms of caring, and we recognise that, but at the same time, and you will see from the discussion in our report we sort of - we want to make sure that we don't say, well, yes, there's mental health carers here and there's physical health carers here and there are elderly carers here and they need to be covered differently because of course for comorbidities there isn't that. I mean you could be all three of those.

MS CHILDS: Or more, yes.

PROF KING: So I was wondering how - when you're saying the mental health caring differs and that needs to be recognised - how would that actually be recognised in the practical supports, or is it the case - so what do you mean, where do you want the recognition?

MS CHILDS: I think for mental health carers it's the understanding that it can be episodic. So with an elderly parent it may be for a fixed period and then that caring role ends. With mental health it can be - you know, recovery is a journey. We've noticed a particular cycle of time. So it is an episodic, and it can be that you're on call 24 hours a day seven days a week for two or three weeks and then there can be nothing, and everything's good for months on end. So I think it's that ability that sometimes there may be a need for more supports and sometimes - but equally you can back off those supports as and when required. Yes.

PROF KING: So we're trying to address that particular episodic nature both in things like a disability support allowance, but also in carer payments and in the rules around the carer support. Do you think we've got that right or do we need to go further or have we not got it right?

MS CHILDS: No, no, I think - I mean I felt that it was covered, but we wanted to emphasise I guess that we agree, and as far as the workplace goes ensuring that there's flexibility around the caring role from experience and from others experience as well who have advocated to us the ability to have a job is actually a good - I hate to use the word respite, but it actually helps. It takes you away from that caring role, it gives you something else to focus on. You have that social interaction at work as well. So it gives you something else I think that - - -

PROF KING: Just as it's good for the person's mental health, social interaction and possible employment, it's good for the carer.

MS CHILDS: Yes, absolutely.

PROF KING: Sorry, just my last one before passing over to Julie and Ann. So we've got material in and recommendations relating to peer workers. I get the impression from your statements today that - you said there's a gap in the community sector workforce that we haven't really addressed. Can you go into more details again as to what recommendations would you want to see. So other than peer workers - so is it relating to training of community-based workforce, is it relating specifically to incentives in rural and regional areas? Where's the gap we haven't responded to? Because we thought we responded to the peer worker, but if we haven't - - -

MS CHILDS: I think from the peer work perspective you have. I think it's about as I said embedding collaboration within clinical and community managed services. In experience we find that works well. Definitely looking at how we can incentivise regional and remote and how that's funded. So within the NDIS there is no - it's incredibly difficult to fund, particularly the very remote if you've got one person, an individual, how does that work. And I think around - qualifications around what psychosocial support qualifications need to be. Should it be a Cert IV in mental health, should it be a Cert IV in peer work, should it be - you know, what level, having that ability to have some career progression as well, because people don't necessarily always want to just be the support worker, they might want to seek further education.

PROF KING: They need a career. Yes.

MS CHILDS: Yes, as everybody does. So, yes, I think definitely around peer work it's captured. It's just how the wider community managed employment could work, and we will reflect more on that in our submission for January too if that helps.

PROF KING: Thank you. Julie, over to you.

MS ABRAMSON: Yes, I'll have a go. An's got my questions, Stephen, if you have trouble hearing me. It's a bit hard to hear (indistinct). It was really regarding - - -

PROF KING: So are you able to hear, Julie. Hang on, one second, Julie. Is that okay for you or is that a bit muffled?

MS CHILDS: I can try. It's a bit muffled, but, yes, we can try.

PROF KING: Okay. Is it better then Julie if An just reads out your questions and then any that she has?

MS ABRAMSON: I think so, because if the participant can't hear me - - -

MS CHILDS: Yes, I can, but it's - - -

PROF KING: It is a bit crackly and noisy. Okay, thanks, Julie. So if you go back on mute and I will pass over to An and An can be Julie and An.

MS TRAN: So in regards to the justice system you had some points around that in your briefing notes.

MS CHILDS: Yes.

MS TRAN: Did you have any comments to make about that today?

MS CHILDS: So we have - I have some specific grassroots feedback about the justice system and the prevalence as we know of mental health issues within the justice system and we were thinking we would actually expand on that. Unfortunately one of the people that has

been providing information has actually had surgery so they've given me very brief - so I will need to expand on that further in the written submission, but there's concern that within the justice system if people don't attend the roll call to get their medication there's no follow up, and that doesn't help them within the general population, and how families and carers too within the justice system can be - you know, if they're outside of the prison system how they can support the person that they would normally care for as well.

MS TRAN: Okay. So you will elaborate on that?

MS CHILDS: We can elaborate on that further as well.

MS TRAN: That will be great. Then I just had a question around - you mentioned a relational lens.

MS CHILDS: Yes.

MS TRAN: Could you explain that a bit more and clarify what you mean by that when you say we need to look at workforce from - - -

MS CHILDS: A relational lens. Yes. So it's how - the way that we look at it is the collaboration and interactions of all the different services. So it's not sort of you have clinical - you might have clinical, you might have psychosocial, it's about having that relationship so everybody is across and has an understanding, accepting that it is a consumer and preferably carer system, but how everybody then works around that to identify the home, the job, the supports that are needed, financial.

MS TRAN: So the relationships between - - -

MS CHILDS: Everything, social determinants, yes.

MS TRAN: That makes sense. Thank you.

PROF KING: No, I think we've covered - thank you very much for that and we look forward to your further submissions.

MS CHILDS: Thank you. I gave that to An before, she has all the copies. So thank you very much. Thank you.

PROF KING: So, Julie, would it be better if we put the phone on the table with the speakers? Okay, yes, that sounds good. So I will just pop you over on the table. The next person Fiona Stewart from headspace.

MS STEWART: Hello.

PROF KING: Hi Fiona. If you could state your name and affiliation, both of which I have just said, but for the transcript, and then if you've got any opening comments.

MS STEWART: Yes, my name's Fiona Stewart and I'm the manager of headspace Geraldton, and I have a small opening comment, I think I've got a page of comments, but I quite like the question and answer format particularly.

PROF KING: Yes.

MS STEWART: And I don't have it nicely typed up because I was writing, and this suddenly became like a university assignment when I read the entire draft report and really had a think about it and I'll definitely work on a submission as a result of that.

PROF KING: That would be brilliant.

MS STEWART: Yes. So I'm representing, what I think I'm representing is youth mental health in our region, and a rural and remote regional context. And just a little tiny background because context is important, that I'm a mental health social worker and I've worked in Victoria, the Northern Territory and Western Australia primarily but not exclusively with young people in the areas of homelessness, school wellbeing, victims of crime, child protection and mental health, and my background is actually (indistinct) education, so it was an incredibly interesting tertiary education journey into mental health. Ultimately I definitely come from a holistic view of the person in regard to health and wellbeing, hence I work in headspace centre. I think first up before - - -

PROF KING: Julie now says she can't hear anything which is slightly - - -

MS STEWART: Well, that's lucky because that was just the intro about myself. Hello to everyone I sort of vaguely know in the room. You'll be all going right, and Jamie will be going 'Ha'.

PROF KING: I will pop you formally back on speaker, Julie, because that may also have an effect.

MS ABRAMSON: Yes. I couldn't hear - I couldn't hear anything, Stephen.

PROF KING: That's all right.

MS STEWART: Hi. Can you hear now?

MS ABRAMSON: Yes. Yes.

PROF KING: Okay. It must be something about going on speaker, it expects the person to be further away.

MS STEWART: Just a summation, a mental health social worker who's been around the traps. So the thing that I wanted to - - -

MS ABRAMSON: Thank you.

MS STEWART: It's okay. So I'm old enough to be experienced and informed about some things, know a lot about - a little bit about a lot of stuff and some things well. I think the stuff I just wanted to comment that national rural and remote strategy I feel really needs to be developed that addresses issues around system challenges and delivering and enabling access to mental health information support and services.

I think of Geraldton - I've lived and worked in completely remote Aboriginal and Torres Strait Islander communities. I've been educated in inner Melbourne. I've worked in regional Victoria, New South Wales and Western Australia, and context like Geraldton, a remote regional centre auspices in a vast sparsely populated area, and there are specific community expectations and issues when you begin to break places up, especially in a massive state like Western Australia.

I think that high priority cohorts in regional areas, particularly Aboriginal and Torres Strait Islander people and young people and people who would identify as isolated, so that could perhaps be any person working in our primary resource sector, really need embedded in a reform acknowledgement around those contexts. Okay. And I was thinking after I'd finished reading this, or partway through, and this is not the place for it, but there's perhaps a philosophical question to ask as to where western - a society like ours is at in terms of this huge burden, what seems to be a huge burden of mental health need, but we're not in 101 philosophy, but there is something in the back of my mind that was just ticking over and over and over again. Some of it the report suggestions, no brainer, of course, yes, definitely. Others, are you kidding, or where's that at, or what's really going on here. So there was a huge overarching macro thing and I haven't quite articulated what that is and I'll probably need to go back and do an eighth year of university to do that.

So there's my little beginning. I was thinking that I actually read it and then looked at some of the reform areas and just have some comments to make under particular ones, but I'm really happy to be questioned on those if something comes up that you think, okay, she's done reform area one, that's what she's thinking, I've actually got this to ask, or you can go at the end, not sure.

Anyway, the biggest one that I had a lot to think about and connected it to some of the draft reforms was definitely under the reform area of prevention and early intervention for mental illness and suicide, and the very first thing I did write was obviously a proactive outreach needs professional and well trained people delivering that service, because I'm representing the context here. I'm not thinking about Perth and I'm not thinking about east coast, I'm thinking about this massive context here, and that the mental health of Australian young people under that reform is absolutely key to the nation's productivity and economic success.

Neuroscience is informing enough now, and it's written in the report around early onset, under 25 years of age, usually between the ages of 10 to 24. There's a developmental context in there. There's a real need for understanding the young brain and the developmental part - the developmental stages that a young person would be at between just that pre puberty to beyond before the consolidated brain.

Youth mental health is so starkly important, and I'm trained from 3 to 70. I could deliver mental health interventions across the age span, but fundamentally once a young person

begins to hit pre puberty to puberty you have an individual emerging, and the context of a child, and children were spoken about a lot in the report, of course, as early intervention as you can get. Then there was a lot of the acute system and I really felt that in there the youth mental health understood as a model and the neuroscience informing it was not actually apparent, and in actual fact I felt that the value of what - you can call it headspace or a model like headspace gives to that age range was actually not understood. I didn't read what my headspace does in the recommendations, and obviously recommendation 24. - whichever one it is - what was your final one, 24. - it doesn't matter. Anyway I'll keep going.

So in this one I just needed to really represent what the potential is for that. So we have - I think it's really important the utilisation neuroscience informs around the onset of mental illness and therefore the type of program delivery that you do. That is really crucial, and if not absolutely the decades of impact on a human being, or where in a Productivity Commission the economy, it's a no brainer. I know it's hard to figure out what that cost is, but if young people are not maintained on their trajectory through school, supported and family supported, well, we've just got decades of taxpayer funded support, but more importantly you've got people who aren't leading lives the best life that they could possibly lead.

The report seems to miss, as I said before the strength of a headspace model and service, especially around the localisation of headspace centres and how embedded they are in their communities. So for instance with headspace Geraldton I completely feel that we've got the flexibility to adapt to local needs and presentations to a degree that no other clinical service I've ever worked in has.

In this headspace we actually miss a key part of the headspace model which is the private practitioners that wrap around it, and in this regional and remote context obviously that means we lack staff and that would be a great thing, but as a result we've got really creative in how we deliver a service, and I can be creative. I'm not bureaucratically restrained in that and I think that's absolutely amazing, and for instance we've got a series of partnerships with a variety of NGOs on a needs based basis. What do we see, what are the themes, and literally can flexibly turn next week if there's themes that need to be addressed for young people and their families, and a key thing for us is their families.

We have got partnerships with private organisations that have been trialled this year and are going into next year which I think is remarkable, and two examples of that are the Port Authority here in Geraldton fund raises for its headspace, and says to us with the money that it's given us recently, 'We want to support you to trial intervention services' - I've targeted juvenile justice for young people - 'and here's some money that we know you don't have in your budget to pay for fuel and vehicles to give clinical intervention to young juvenile justice fellas.'

Also a national conservation organisation has come on board for us in this region, in the mid west. We're trialling with Bush Heritage Australia using the land that they own to take young people onto it in long format. Bush adventure therapy is what we're just trialling for a cohort of young people. That's a private partnership.

We have got placement of staff in schools for priority groups. We assess our data, where are the young people, vulnerable people, who cannot get to our headspace, our bricks and mortar headspace, we're funded, no bells and whistles headspace. So primarily in our region we looked at Aboriginal and Torres Strait Islander young people, particularly male young people and said how do we get to places where we can offer services to them, and currently - I got our happy results today, our data off today, and we are sitting at 29 per cent of our clientele is Aboriginal and Torres Strait Islander young people for what is a mainstream service essentially, but what it says is we've got the flexibility to say what does our community need, this is what we need to do, and how we have done that is being able to put staff in places where young people are and creating models of intervention - not assessment - I'm not using words like that - ways of hearing what they need.

I have three staff working with Year 7, 8 and 9 Clontarf Academy, which if you're not from WA is an Aboriginal and Torres Strait Islander young male engagement in schools program. One of those staff has been with the same boys for two years, and he'll be in Year 9 with those boys and he'll go through and graduate. And the staff had a meeting with me this week, who said, 'We're beginning to see the benefit of that imbedding.'

Over time, the boys now approach that staff person and they ask for one-on-one conversations with him and they're coming to the bricks and mortar headspace which is, like, extraordinary, but it took time and commitment out of one-on-one clinical time within a headspace to say, 'That priority group needs something really different to get to know us and to get to know how we work and we need to get to know them and understand who they are and where they're at.'

We've been delivering an outpost service delivery model in the mid-West to a couple of sites to see how it goes from a clinical perspective which essentially means we go out to a couple of schools that were saying, 'We're desperately in need of help, please,' and set up our clinical model and community engagement model on those sites for very, very vulnerable young people who were never going to get into town.

And what this does is provide multiple access points and multiple ways of supporting young people and the model that I work under enables us to do this because I have the auspice as the manager to look at the data, to make sure I justify our spending within the context of our contractual agreement, but to say, 'This is what our community needs,' and do it and our statistics around LGBTIQI+ and Aboriginal and Torres Strait Islander young people are huge for a regional area and I think that's a flexibility as Geraldton's headspace and the community recognises, and the community recognises at Geraldton's headspace.

Just the one key pathway that I think is really important in terms of for friends and family and particularly for vulnerable young people is we created what we call is 'got a lot going on', and got a lot going on is essentially no wrong door; if a young person walks into our headspace within the headspace priority groups, which in our region are all young males, Aboriginal and Torres Strait Islander young fold and culturally and linguistically diverse. You can identify sometimes those young people.

There's no intake process; there's no 'can we re-book you in?'; we've created a special pathway that the attitude of the staff is 'we see that person now.' No case write noting is more

important than seeing a young person and families come in, and grandmothers and parents and particularly for our Aboriginal and Torres Strait Islander young folks, they are heard there and then where they're at because help seeking for all young people is situational and timed and asking a young person to come back in three weeks because, actually, our intake is full and we've got a week wait list is not okay for vulnerable young priority groups, and I feel that headspace Geraldton has done the best it possibly can because we've been given the flexibility to do that.

So that's in the acknowledgement that I understand that the commission is looking at prevention and early intervention and it's key; it's absolutely key with that embedded word of flexibility, wrapping it around.

Program creation for young people in terms of - I mean I mentioned bush adventure therapy for juvenile justice, young people in our community, but also friends and family embedded practice and as an example offering absolutely regular family information services on a weekly or bi-weekly, you know, opportunities. Information sessions, single session family consultation is so important to the care of our young people and they are able to identify who they would like as part of that, and we ask every single young person, 12 to 25 years of age, 'What name would you like us to put down here?' and this is the type of information in terms of psycho-ed we share with them, not the young person's story, I'm talking right at the front end of practice, and families can book in with our clinicians on any basis that they want to talk about where they're at, and the conversation is clearly had with young people around what that means for them in terms of confidentiality also.

The only other comment I wanted to make under the reform area was under the senior teacher emphasis, and I was suppose a little bit confused by that to a degree. The best practice that I've worked in in terms of well-being in schools was in Victoria where I was a mental health social worker, I was the well-being person. So a principal hired me and put me in there and the sense of that - I'm not teacher trained. I sat in an office and was experienced - social workers are - the teacher thing was interesting because I feel for education where the burden of psycho-education and the emphasis on change being placed into teachers and upskilling teachers were, to a certain point, What's their core business? and then, What's their expertise? And when does it just get too overwhelming for them.

It is an absolutely no-brainer to me to have people who are trained in expert - around how systems work. So I'm not talking family therapy in schools, I'm talking systems work, and I think though, maybe that's more a comment than anything else that it just made no sense to me about labelling 'lead teacher' 'senior teacher' rather than - there are people who are trained to do this, who could be employed by education to sit in a role that means their practice is very flexible and they're completely across how to work with families.

They know what their community's referral systems are, what resources are available, why wouldn't you use that workforce instead of the teacher one - the lead teacher concept or senior teacher concept - and then creating - it occurred to me also in there that sort of what, perhaps, consumers and families are asking is a type of headspacey sort of model for very, very young people which is, you know, that primary school parents and teachers can access, that is totally around family support and an early identification and looking at young people who come in from marginalised backgrounds and putting that support in very, very early obviously makes

sense to me. Headspace is an early intervention if it starts at age 12, but what our headspace model is a youth model beginning at age 12 is looking at a neuroscience perspective of brain development; and that's all I had to say about that one and that's my longest one.

PROF KING: All right.

MS STEWART: The critical gaps; of course alternatives to Ed's are really important and creative partnerships would have to be formed to make - when I looked at the reform dot points, what was being commented on, and I think from a perspective here, it would require a dramatic practice shift from state mental health systems. Not people who work in state mental health and not intent and heartfelt and internal motivational capacity, but rather systems trying to work together.

Experiencing, you know, a funded NGO headspace, trying to work with a state system, is actually incredibly difficult at this point and I think that that's going to require a dramatic practice shift from bottom up and top down, and in a region like this, it just makes sense to me that something like - and I don't know if (indistinct words) is the latest way of describing anything, but for acute care strategically placed and based, particularly for young people and Aboriginal and Torres Strait Islander young people so that they don't have to leave their regions, ever, under an acute care setting is a huge gap where we are.

And it occurred to me that I don't know how creative the commission gets to be to how it looks at what complete change is because I'm for rebuild the system personally - rebuild the system. But have you looked at the Trieste model after deinstitutionalisation in Italy? In Geraldton, when I hear consumers and consumer advocates speak about what they would like or when I hear adults come into the headspace door and say, 'I wish there was a service that looked like this for me,' and it's because it's got great couches and cushions and a dog, and a whole lot of really wonderful stuff going on and it's purposefully fit out like that.

But the 24/7 short-term care doesn't make sense in that Italian model. It seems to be that a region like - you know, and that model is based on populations of 50,000 - it just seems to make sense to me that that's the sort of stuff that I hear consumers and adults particularly, talking about young people are keen as mustard to come into headspaces but their carers and also adults who walk into headspace and say, 'I was told this would be a good place to come but they're out of our age range.'

Number 3; the investment in services beyond health (indistinct) housing. All I can say is, 'Of course,' and it's a huge issue for young people in our region. 'There's a wonderful housing organisation and it's chockers,' and there's not really an interaction with the state government housing very well I do not think, particularly for young people.

And number 4; the work, and obviously, the IPS' are known to be attached to some headspaces and those headspaces are seeing great outcomes; we have nothing here at all and it's a huge gap. We have a vocational person but we don't have a program and this goes back to my original comment about regional and remote specialist embedded situational stuff within the reform package and under care coordination and governance, the one thing that stood out to me was the single care plans which could be an amazing thing and it would

really need some mechanism of making that happen that where state and regionally funded services comes together on that.

It just feels like bureaucratic nightmare to overcome but could so simply be utilised. Like, this makes complete sense to me but in order to do that, it would take time and funding to, from a practice perspective, pull that off well. To look at that caring coordination with a whole lot of services, particularly from a clinical perspective that could be working with a young person, which we try to do, it takes time and time, it needs funding because some people look at KPIs. I don't particularly necessarily, but I know that that is really important; and that's it.

PROF KING: So a few questions that I've got coming out of that. Thank you very much. So headspace is a very interesting model and our recommendations relating to headspace basically say, 'Well, as with every program, it needs to be evaluated and it has to be making sure it's meeting regional need,' and from your comments, it certainly seems to be meeting regional needs here in Geraldton. But we don't get a consistent story around Australia and so I'd be very interested in you commenting on how you've found the headspace model, because it is a franchise model.

We've certainly had conversations that say, 'The benefits of that is that it maintains' - I can't remember what the clinical term is but, you know - - -

MS STEWART: We're (indistinct) governance and - - -

PROF KING: No, but lately on the clinical side as they say or it sort of maintains integrity of the model which seems to suggest a lack of flexibility and we've heard from some others that, perhaps, in their regions that the headspace model, perhaps, doesn't have the sort of flexibility that you're talking about and I can't judge whether it's meeting regional need, which is why we recommend, 'Well, it needs to be evaluated,' and then it has to be up to a regional body to work out is headspace meeting a regional need.

So, I would like you to comment on that because your experience with headspace may be different to others but I really want to - have you talked with other headspaces?

MS STEWART: Yes.

PROF KING: Do you find that the franchise model limits you at all or is it really - I mean you painted a very good picture.

MS STEWART: Yes, well, I'm a graduate of the clinical assessment of Melbourne Uni and the model came out of that to a degree. Totally; and I know it's not even a gut inclination answer it's - I think about these sort of things all the time. It's the lead agency; it's a very strange model and I can guarantee you that flexibility - because the model, remember, has a lead agency and the lead agencies are all different.

PROF KING: Yes.

MS STEWART: And I very much think that that probably could answer some of your questions around how do some headspaces seem to do some things and others not and the lead agency - so essentially, when you're a manager, you have you have a PHN person you report to, a lead agency operations manager and you have headspace National, all three asking you to do things at any given time.

It's a strange model of governance and contracting. So if you're lead agency manages you well, and I feel like our lead agency obviously does that because all of the things that I've described - I do know some other headspaces are sort of like, 'How did you manage to pull that off?' You always have to have fidelity to the clinical model. I'm a clinical person.

PROF KING: That's what I was after; fidelity. Thank you.

MS STEWART: Yes, but that's because you are informed by neuroscience.

PROF KING: Yes.

MS STEWART: I'm utterly and totally formed with the best practice that we can that's coming out of - and we're now moving into a whole lot of behavioural stuff with our really early intervention young people and - anyway, no, won't go into that. That would just take us off somewhere else.

That makes sense to me. It's the lead agency context I think is what can really vary what can go on for headspaces and whether they get the resources they need or not or the flexibility to deliver. So Broome headspace has a fleet of four-wheel drives out the back 'cause it's lead agency is the Kimberley Medical Centre and they get that you go bush. They get that; we're our young people.

PROF KING: Yes.

MS STEWART: So I think that answers part of that question.

PROF KING: So we've heard criticism that, you know, headspace is very unusual at the moment in the sense that whilst some money comes through the PHNs, it is directed money. So the local PHN's are - and obviously 'local' has different meaning depending on the different states because they have different number of PHNs, but let's say the local PHN doesn't have discretion over those funds, and we've heard from both sides. So we recommended that over time, that it should be - whatever the local funding authority and we've got options there - but whatever the local funding authority is, it should be deciding whether the headspace is the appropriate way to deliver services in its region or not and, you know, some people have said, 'Yes', and some people have understandably said, 'No, that would be terrible. That would undermine all the gains that headspace have done.' What's your view on that?

MS STEWART: Would you like to hear my summary? Because that's exactly what was in my end statement.

PROF KING: All right, please, yes.

MS STEWART: Okay, in my summary I just said, 'Staff bleed green,' and I make no apologies for that because we work in a service model that, although not perfect, is the envy of the world in youth mental health delivery. It's a national, flexible, clinical model and it is a flexible, clinical model, it really is; that delivers to communities and engages young people at critical developmental times. It's informed by latest neuroscience and is and can be creative and flexible.

The 24.2 draft recommendation that we're talking about at the moment, I've written here 'that PHN's not funding headspace centres'. I mean you compare (indistinct) it could be the new model that you were talking about when you collapse it altogether and it's re-pulled out - sorry, Amy.

PROF KING: Whoever the commissioning bodies are.

MS STEWART: Yes, whoever it is.

PROF KING: Yes.

MS STEWART: We're a small population in Australia. You know, we're New York city and an entire huge nation and some of this is like, 'How are we not getting this right?' is that it really would be the beginning in the end if you pass that through because what happens to a place in regional - when there is a model that you can look at that passes clinical expertise, has a whole lot of other engagement arms to it, absolutely embeds friends and family practice, is out in the community and is known and is accountable to mental health commission frameworks and is accountable to chief psychiatrists and can be audited on any given day, I don't know who Amy would actually turn around and get in to replace that and eroding that national network it would also erode consistency because there is a level of - so when I say, 'Staff bleed green.'

I've got an allied health team there who are made up of nurses, master's in counselling, mental health social workers and clinical psychologists at the moment, and all of them have worked in diverse mental health arenas and they literally bleed green, now, to the lead agency sadness because they're not green; they're a different colour. Yes, so I think it would erode the consistency in standards that community and parents have some expectation around.

PROF KING: Okay.

MS STEWART: Remembering that in a region like this, we have an early intervention headspace which is - which takes on clientele far above, even though we've been asked perhaps not to - what our funding auspice is, and you have a very busy state system and that missing middle is definitely an issue here, because there's not a service provider for that missing middle.

PROF KING: So again, just - should be a question coming through. Just to push a bit further on that though. Given that headspace is so good for this region, wouldn't anybody looking at regional commissioning say, well yes, headspace continues, there's the money for it, and we now need - you know, we've got other money for the missing services that need to

be provided for. So I just find it odd that everybody says we want regional solutions, but the one program, and there is only one real program in psychosocial support in the mental health space, perhaps is a better way of putting it, that is, it will be run, is headspace.

There is that direction from the centre which seems to be completely against that, well, you have a regional governance model for what is needed on the ground in the regions, it's a very, very, centrally controlled funding process and I just find - and the defence is, but headspace is doing a great job, so surely we've got to keep funding it. My response is, well headspace is doing a great job, so they will get funding from the regional funders where they are doing a great job.

I'm really struggling with this. We want regional, but we love the central - the centre has said, these will be funded. It's not a regional - headspace is not a regional funding model. It's a centrally drive Commonwealth - - -

MS STEWART: No, but your practice is.

PROF KING: I understand that.

MS STEWART: And that's what counts for people.

PROF KING: Yes.

MS STEWART: And so, I really think the lead agency is your question there, and that's perhaps then a PHN responsibility to look at lead agencies and make sure that they're allowing the headspaces that they have gone out to tender for - you know, are they an agency in the region that's been tendered for, so you understand your region. That could be questioned. Or is there a flexibility. Do you hire managers and clinical leads that are qualified and skilled enough for you to let off the rein to do what they need to do in their region? They're the sort of questions that I would asking of PHN around the lead agency.

PROF KING: Okay. So I'm really going to push this, because it's a - it is - I think it's really important. Let's say we take the - and I'm picking on the Kimberley for any particular reason; headspace services up there are fantastic. Kimberley, very large Indigenous population. We've heard from many Indigenous representatives that they feel Indigenous controlled organisations are a key to improving mental health in Aboriginal and Torres Strait Islander peoples.

So again, let's say we go to a - went to a regional model and they said, well, Kimberley headspace is fine, but it's actually not meeting the need because it's not Indigenous controlled. So we're going to defund headspace, but we're going to have Indigenous - because we need those funds for more of the Indigenous controlled services, and we make that decision on a clinical basis at a regional level. What's wrong with that decision? Because under the central headspace model, you're saying that decision cannot be made. That decision is ruled out centrally.

MS STEWART: I don't think I'm saying that, and most of that makes sense. But what you're asking for - and also, I think, you know, you can put - you need to be able to pull back and have a look at what the determinants are as to why - and poverty is a key one here.

PROF KING: Yes.

MS STEWART: Poverty is an absolute key to the ill-health of young people in the Kimberley.

PROF KING: Yes.

MS STEWART: It's the one common factor across all of it, and no headspace is going to change that. No headspace can deal with it.

PROF KING: Yes. Poverty, trauma.

MS STEWART: Poverty. Exactly.

PROF KING: There's a whole range - - -

MS STEWART: No, no, not trauma. I'm using the word 'poverty' specifically. Headspace is working - can work in trauma, but they can't - they're not the mechanisms of government to be able to deal with poverty, and intergenerational poverty, and their health determinants that come from that, there's a piece in there that you can work in. An expanded workforce that works collaboratively, or works side-by-side, is possible.

I mean, our headspace has 29 per cent, as I said before, of young people, and that's those young people who want to come in there. If there was another equally robust service that they could access, maybe they would too. Or maybe they wouldn't. Lots of young people come into headspace because it's not related to people that they know. Twenty-nine per cent comes from people accessing it. They're making a choice.

PROF KING: Yes, all right. Sorry, I'll just quickly see. That one. I've done that one, I've done - all right.

MS ABRAMSON: (Indistinct).

PROF KING: All right. Sorry, Julie. Yes, I'll let An ask your questions, I think. I've done all mine. Sorry. An.

MS TRAN: We can get some questions - - -

MS ABRAMSON: I think what we might do (indistinct) to have - we could take my questions on notice. I just wanted to know more about the (indistinct) aspect (indistinct). Happy to receive that in a submission or just in email form, and then the other issue was related. How does the (indistinct) community - how do they get to the services? Like, what's their outreach program that brings people in. But happy to have those on notice.

PROF KING: Are you happy to take them on notice?

MS STEWART: Yes.

PROF KING: Because yes, I have completely blown the time (indistinct).

MS STEWART: Yes, yes.

PROF KING: And An, did you have any other questions? No, all right. Thank you very much.

MS STEWART: That's okay.

PROF KING: Thanks, Ms Stewart.

MS STEWART: Thank you.

PROF KING: I've now blown our morning tea time. But can I suggest we still take a morning tea time. Perhaps 10 minutes. If we can come back in here about 11.07. Very specific. All right, 11.10. I suddenly realised I hadn't changed - - -

MS ABRAMSON: Sorry, Stephen. I'm sorry, Stephen, I didn't hear. When are we reconvening?

PROF KING: So, we'll do it at 11.10.

MS ABRAMSON: Okay. Thanks, Stephen.

SHORT ADJOURNMENT

PROF KING: Okay. You're fine? Yes. Let's start again. So, Clare, if you could state your full name and organisation, and make any opening comments that you would like.

MS GREEN: Great. So, hello everyone. My name is Claire Green. I'm from Elucidate (indistinct). For those of you who don't know, it's a funny word, but it basically just means to make things clear, a bit like illuminate. So I have worked in multiple sectors, including the private sector, the public sector, and the not-for-profit, or community managed, as we now call it, sectors. And so my role within Elucidate as business owner is basically just to consult on various programs, projects and modelling, as well as professional development training for staff.

So in particular, the areas of trauma informed care, as well as protecting the workforce for burnout and fatigue and vicarious trauma, which is quite prevalent within our workforce. So my comments today, as opposed to relating to a particular program, or organisational agenda as such, is more just to see and comment on the sector-wide issues, which is what I'm quite passionate about, is that leadership and innovation within services.

So my comments are really just broad comments around some of the recommendations that I've seen as I've worked with a lot of different parties on the ground, including consumers and families, as well as organisations. So I'm just giving you some broad detail today. So, all good to start then, with the formal - - -

PROF KING: Please.

MS GREEN: Okay. So, the first thing I wanted to do is start off with the IPS model, which I'd like to say that in theory is a really sound model in that you are utilising an employment consultant with the community mental health service. But I do note that sometimes it's been a bit hit and miss in terms of the consistency that has occurred on the ground level, and partly I think that is because in the sort of employment agency (indistinct) organisations, I was working as an employment consultant many years ago, before the star ratings came on board.

And we could be a lot more flexible in terms of who we worked with, how we worked with them, and could be a lot more holistic. When the star ratings come out, it forced employment agencies to be very efficient and driven solely by KPIs, and I think where the IPS model can sometimes fall down is if a particular employment organisation actually has a contract, but then suddenly the star ratings aren't that great, or have decreased, they're at risk of losing their funding, which means that IPS consultant who's based in that employment agency, you're going to lose that IPS consultant because they're going to lose their job, or they're going to have to be reallocated to a different location.

I understand that would probably work quite different regionally than in Perth metro, but that's just my understanding and experience so far. So I agree with some of the recommendations in the draft report about maybe looking at employing an IPS consultant directly in the community mental health services so that we get some consistency, and also to that, employment providers in general are not necessarily biased.

So, for example, the way I see it working in a positive model would be that the IPS consultant is embedded in the community mental health service, paid a wage by the community mental health service to continue consistency, but then linked with a lot of different employment providers, which could be the consumers choice. It could be the choice of the community mental health service. It might already have some great partnerships and collaboration going already, but it would just sort of link in that consistency.

Also, to get specifics, because I'm also really interested in the practical level of service delivery, is that I would also arguably say that the IPS consultant needs to be paid, obviously not a clinician wage, but a higher wage than a typical employment consultant would in an agency setting. Simply because the complexity and acuity that you get in the caseloads of community mental health can be quite high, or higher than a Aboriginal employment agency.

And also, because you are working within a multidisciplinary team, which in a clinical model is actually quite specific and has a lot nuances that are quite - can be quite different than other multidisciplinary teams in, say, a not-for-profit sector. So I would suggest that they do actually get - that when things can be initiated, they are actually recognised for their expertise

in that area, and employed as a specialist as opposed to your average consultant. So, is that okay if I just keep going through my points?

PROF KING: Please. Yes, yes.

MS GREEN: Or do you want to stop me at any time?

PROF KING: Yes.

MS GREEN: Okay. No worries.

PROF KING: We'll have a bit of a discussion about these.

MS GREEN: Okay, great. So the next one is on - just a brief mention on the non-legal advocacy services. So while I recognise it might differ for different bodies in different states, and maybe some different platform services, my - I'm still getting consumers and carers and families not actually knowing that there are actually advocacy bodies available, and I'm not talking about sort of Legal Aid or your mental health law centre kind of advocacy. I'm just talking about your general advocacy services.

So I think it's really important that we make these services explicit. I think, as workers and the staff and managers within organisations, we're quite aware. We network quite sort of widely, I guess, to say, in terms of knowing what networks are out there. That's sort of our job. But it's not really a family's role or a consumer's role when they're unwell or not feeling great, to suddenly try to network and work out where an advocacy service may or may not lie, and how the deal or don't contact them.

Especially if families are overwhelmed and stressed, and consumers are overwhelmed and stressed, typical communication and phone contact and face-to-face meetings can be quite difficult at those stages. And I also believe that we do the mandatory note of telling people their rights and their responsibilities, and we might even give a great little informational share pack, but if someone is feeling unwell or overwhelmed where that family member is really concerned, you're not necessarily going to go to the brochure in your pack to work out what's happening.

And as individuals in this room, we don't have brochures in our back pockets to say, that's right, I need this emergency service. That's just not how the average person works. And so we need to treat mental health people, like the Aboriginal person, in that we need to make sure that information is explicit. So I think it needs to be mentioned in ED departments, in inpatient facilities. I think that at the community service level, we're a lot better at that, but I think, in those critical moments, we need it to be explicitly mentioned.

But I would also go further and suggest visual displays. If we had a wonderful visual, and there's no reason why an amazing graphic designer couldn't work with - excuse me - you know, someone from the health department. And I say graphic designer, because it has to be eye catching, like the person wants to make a phone call, not another government document.

That it is actually visual and eye-catching on the wall, and it's actually placed there. So okay, you know, if I was to be a consumer a family in my first day of care, I might be too overwhelmed to call an advocacy body; but if in my fifth day, and I see something eye-catching on the wall and I think, "Yeah, actually, I really would like to talk to someone outside of this service. I know exactly where to go and it wasn't in my tenth document in my information pack on day one when I've lost it already on day five."

So I just want to be really practical in that regard, because I think there are lots of little changes we can make at the real practical service-delivery model level, that doesn't include a mass amount of funding on just information and communication.

The other idea that's already talked about today, and I just want to put a slight addition to it - I won't go on for a long time - is the idea of social and emotional learning programs in the education system. I, very like Fiona, sort of started way back in education and then weaved around eventually to mental health, so I've been a teacher before and I know what that's like.

My question, which might be now out of date, I'm not quite sure, but why aren't we utilising school psychologists? Because I know - and I've still got friends that are teachers currently - that they are at the forefront of seeing when intervention should occur, they know when little Johnny for example, is quite different from the other 29 kids in the classroom, or the 25 or whatever states cap their numbers at. But the help for the teacher to then get assistance or referral pathways or networks for that little Johnny can be very time-consuming, and often takes more than the school year, if it's a complicated case.

I know sometimes school psychologists can actually be - and again, this might be just the metro area - spread across multiple schools, so I'm just wondering where - and maybe you can let me know later on, or whenever - what are we doing about that and is that something that the Productivity Commission thinks is going to be phased out, or is it something that we can support and actually you know, resource and fund to actually come in and do that early intervention stage? So just in addition to what's already been said.

And the other thing that might be a little bit controversial: you had some recommendations in the report in terms of improving training for doctors, and with doctors I took that as GPs and psychiatrists. And I guess what I'm asking is that we already know sometimes that GPs struggle because we really only have community mental health service, emergency department and GPs, so if you're not in the other two you're probably going to go GP. And we always tell people, "Just go to your GP, you'll get some support."

But we know that GPs - not all of them, but some - are saying that their allotted time appointments in terms of creating mental health plans and care plans is quite short, and they don't feel like they've got enough time. Sometimes it can be quite overwhelming for them to navigate the different referrals and support services they can add into that plan, and linking to, as well as just being able to have the confidence and experience to address that kind of niche area that might not be their every day-to-day kind of work.

I do recognise that I think the regional areas probably do this a lot better than the Perth metro areas, in that everyone in the regions know the regions, which is great. And I think the Perth

metro area can learn a lot from regions. So just to be transparent, I am from Perth metro but I do regional workshops; I am very interested in this meeting.

So I guess what I'm saying is that there is so much siloed effective services, and I'd imagine there's even that between the regions, so what Geraldton and the Kimberley do will be completely different, as opposed to what Perth metro does. So my point is not just on adding more specific training around professional development points or you know, accreditation or things like that through AMA, but what are we actually doing to train them up on the ground, day-to-day, face-to-face kind of training that we need?

The other thing I guess that I wanted to say is that I always hear a lot of talk about medication and I am for medication; when that happens in a beneficial way for someone, it can radically change their life. But if we are only talking about training in administering, recognising, you know, prescribing medication or treating diagnoses, I feel like we're missing a key training component, which is in recovery-orientated services, trauma-informed care, which actually directly results in how someone presents.

So you can try and go to diagnostic criteria and hope that you get it right, but a lot of people said determinants this morning, and I feel that the training for doctors and psychiatrists actually needs to be around some of those determinants, as opposed to the sole clinical/medical model of brain and body.

I totally know that brain and body is the main thing that they are qualified in, but I just wish that we could maybe add a different level of training that would maybe help them feel more confident in their day-to-day communications with people coming in, because I think that's really important; even things like co-production planning for services programs; even how to actually do a care plan with someone and actually make sure that that communication dialogue is equal and really beneficial for both parties; training on that actual practical element of, "How do we do this well, and how do doctors actually feel really confident in doing it well?"

I feel like that's something that gets missed out of the formal professional training suite that we make people do. So just as again, very practical. And also, another thing - and Fiona mentioned research from Italy which I think is great - because the other idea with training is that we're not just making sure that people doing evidence-based practice in their day-to-day, but what are we globally looking at, what are we globally researching? So for example, in other countries there are people with schizophrenia that can work full-time and they have high success rates; over here, if you've got schizophrenia, you're lucky if you ever work again, and people will tell you that, unless you're a recovery-orientated clinician or professional, and then there's much more hope.

So what I guess I'm saying is, how can we make sure that training aligns with relevance and currency, and not just a textbook model of training and qualification, and how do we do that? And does that then relate to the tertiary institutions having KPIs on their training and how they can actually maintain relevance and currency on what people are studying?

Because if we're studying the same thing now, in 20 years, well, then we've got something wrong; if we're studying the same thing now, in even a year or two, we're probably not

moving with what's happening. So we can add additional training once they're in the sector and they are working, but how about we start right with the tertiary institutions first, and keep them accountable because they do get paid a lot of money to teach.

So then I guess what's also been talked about in terms of the guarantee of psychosocial supports; this is a big one for me because I have a lot of networks in the not-for-profit sector. I do believe and agree with the submission so far - sorry, the draft report so far - that it is optimal that the contracts be extended for psychosocial ports. And that additional measures should be considered to support those who have not been eligible or not want to apply for NDIS, through that national psychosocial support measure.

But I really want to note - and I can't stress enough, because I am very aware that I represent lots of different roles and lots of voices - that funding for such contracts needs to be funded enough. So what I am hearing on the ground from a lot of different not-for-profits - and this isn't breaking confidentiality, this is just sector-wide issues I'm talking about - is that they are worried about their business model, and they're worried that the funding for such other models, the psychosocial support that's not in NDIS, post this year measure, that it won't be enough money to cover things like vehicles, to cover the one-on-one kind of work.

And a lot of places are talking about you know, group activities instead. And I would hate that the funding for such psychosocial supports is so short-changed or reduced because we think NDIS is the answer, that the people that fall through the IPS actually are left with very minimal funding, and you've got services and workers that don't know how they actually provide the same level of care and support, in a different model.

So my comment would be that we make sure, or put some steps in there, to make sure that any psychosocial support models post-NDIS, post the national measure, is actually adequately funded and is not a substandard or subclass of the NDIS, because that means that people actually are not getting the care, and they're actually disadvantaged by NDIS, rather than advantaged by it.

In saying that, I am all for NDIS when it works really well and for flexible, individualised, tailored funding; I just think we need to be careful of lumping mental health with disability, when there are a lot of people that don't believe disability and mental health are the same thing. People can be debilitated with mental health, but not necessarily disabled; that's just maybe a controversial opinion, though.

So yes, so just the point would be to make sure we adequately fund whatever moves forward, because people out there are a little bit scared of how they're going to fund their staff, of how are they going to lease the premises, how are they going to pay for their vehicles, and what programs they can come up with, with substantial reduced budgets.

Another point in terms of the wellbeing for leaders in schools - and it's already been talked about - what I will just add to is that we need to be careful that we don't add another one tokenistic person within a school, because I don't believe it's enough to create transformative changes. And I think when we do one of everything and just place it in the middle of a big context, that it puts a lot of pressure and strain on that person.

I also wonder, can we co-ordinate more services that are already existing on the ground a little bit better, in terms of we've got chaplaincies, we've got student services, we've got administration teams, we've got group programs; schools can also bring in youth programs that they feel would meet their needs. A great example is headspace here.

I'm wondering if we just need to collaborate a little bit more and work out something locally, or something like a clinical service or a not-for-service that's got that specialised arm that can actually do a better job than just trying to train-up one extra teacher. And also, it's very hard to retain teachers sometimes in the workforce; we've got an ageing workforce in teaching, so we need to be careful that we're not scaring them away by more pressure, which has already been talked about.

Then young adults and tertiary supports are linking their online services and resources. I think we can actually learn a lot from TAFE systems, because I think as much as the TAFE system does include a disability support adviser - and I don't really like that title - but they do have models to actually plan and get that person through that qualification; as opposed to a university that is generally quite a big system and if you're struggling, the stigma of saying that you're struggling can be harder, especially depending on what you're studying and if mental health would be a good option, or a really dangerous career move to admit to.

And I think we need to be very careful that we do actually plan that people can finish studying, because often it's not always a mental health crisis; sometimes, it can be a situational thing that happens. And we need to address that, and the stress and anxiety and trauma that might go through an incident or an event, as opposed to think that we're going to have to babysit someone for the whole of their degree. Short, little bursts of intervention can actually do a really good deal of help and assistance.

Also, then if we're talking about tertiary supports, we need to make sure that whoever is in a role or whatever kind of links to services happen, that they do know what their links and their referral pathways can be, that they do know what supports they can actually link into.

The other thing that I also would like to mention is something that is quite cost-effective; you were talking about links to online resources, end services. It's actually just making it, again, really practical, making it in the platforms that they're working with; so university today is all pretty much completely online; you've got blackboards and other platforms where everything is submitted, read, downloaded, viewed. Why don't we just have a link on there that says, "Look, are you stressed, overwhelmed, got any mental health issues or concerns? Click here for some support."

It could be as simple as just adding a little icon on a digital platform page that then has the reference to the number of support services, pathways, or even just to see the GP, as long as we support GPs enough. You know, there are little things that we can add on the day-to-day that doesn't have to be the big picture stuff; it can be at the localised level, just adding little communication aspects to make it easier for people to then get online help.

In terms of governance and evaluation, I realise that it's a little bit controversial, but I do like to be practical and also forward-thinking, and so my question is, what's going to be done to ensure that any new inter-jurisdictional statutory authority will remain and be sustained

through a bipartisan approach, to eliminate wastage of resources in completing reports that arguably don't amount to long-lasting change. And can this authority be objective and un-politicised for the good of its noble intentions?

As much as I love getting together - and I really actually love sector collaboration; I think it's so important, and we should do it outside of report phases, just for our own professional development and benefit and networking - but I worry that as we churn out more reports, are we actually going to see the sector reform change that we need? And anybody that gets created, peak body, statutory body, whichever body gets created, it's really only as effective as what it is legislated to do, and how long someone is in government for.

So although I welcome such authority in such a body, I would want to see that there are some objectives and some boundaries, and some limitations, or just something to the effect that it can be sustained and maintained long-term, especially because change doesn't happen overnight and it won't happen within an elected government term.

In terms of structural reform, I support the rebuild model; that would be my preferred choice. However, what I'm also really interested in is what I'm passionate about in this state, is what's being done to allow for innovative models of services and facilities. So in terms of legislation, commissioning, licensing, accreditation processes; sometimes they do limit the scope of what can be provided, and they can restrict innovative practice and new models of care and service delivery.

There needs to be investment and commissioning for both the clinical care aspect and the community aspects. And I'd also argue that whilst both are incredibly important, it's also good to note there can be hybrid models of wraparound care that can use both the clinical and the community, and can be of benefit in servicing and consumer needs.

Again, (indistinct) a little bit, say, is that there also needs to be strong consumer and carer representation with such governing statutory bodies. And I would even recommend a sort of a bit of a workforce target and quota; again, might be slightly controversial. But to ensure the inclusion of the voices are actually not merely a representation or a role that is an hour meeting, or read a document and give us what you think; but actually at the decision-making level to plan equal role on the body that actually gets developed. I think that's very important if you want it sustained, long-term.

Then lastly in terms of the private health funding and funding community-based healthcare, which is something that I've just been interested in, in this recent two years. My main point is that there needs to be key legislative changes so that private health insurers can actually remain confident of the quality of such a service in adhering to fundamental accreditation and licensing that are not currently within hospital services' frameworks.

At the moment, there is no provision for community-based care within legislation, and if we made some changes - so at the moment we've got hospital and we've got day hospital programs, and then we've got, you know, psychology sessions, but there's actually nothing community-based. So if we allowed the change to the legislation, private health insurance could actually fund models that were out of the hospital services framework, then we could

actually pave the way for innovative and cost-effective models to be initiated and also sustained, which would create less of a burden on the wider system.

And they were my points. So, any questions?

PROF KING: Thank you very much. Okay, let me start at the end first. So getting the consumer voices in any rebuild models, so getting the consumer voice at the local level, also the consumer voice at the national level, the NMHC - and as a bit of background, with any government body, you can't stop governments from changing and getting rid of - - -

MS GREEN: Sure.

PROF KING: They could eliminate the PHNs tomorrow if they really wanted to, or they could completely revamp and they could sack every local hospital board in the state if they really wanted to. So there are simple government restrictions that you may like to get rid of, but we live in a democracy.

MS GREEN: It was wishful thinking. Wishful thinking.

PROF KING: We live in a democracy and we elect governments, and we give them relevant power, or they have relevant powers; we may or may not like how they use them. But sorry, I went off the track there.

So we suggest things like having consumer representation, lived experience at the board level in any new organisation that's being set up. Do you have any suggestions as to how to embed it further in organisations, to make sure that those organisations really are consumer-oriented, rather than being captured possibly by a clinical group, or possibly by other groups; so any thoughts about that?

MS GREEN: I think sometimes we don't give consumers and carers - I'll put them in as well, as equals - that we actually think that if we involve a consumer or carer that we're just going to get a nice little story and somehow we fit that nice little lived experience story into our model and hope that we've got it right.

But I think we don't give consumers and carers enough credit, in that there are consumers and carers with degrees; there are consumers and carers that have specialisations in niche areas; there are workforces that have already been set up - which I won't go into, but we could always have a private chat about that; there have been workforces already that have made a difference in certain ways.

So I think we just need to be careful that we're not employing people just to give a story. You know, consumers and carers can be screened just like any other worker or any other employee. Because I think there is a talent in being able to navigate administration, service delivery, policy development and making, and all those aspects.

But we shouldn't just restrict consumer and carer involvement because we haven't worked with them before, or because we maybe don't understand their training or their experience. We actually need to have a more thorough discussions with them to say, "Look, this is my

role, this is what we're doing. How do you see coming in and assisting us, and what's your level of expertise and experience?"

Obviously, lived experience and the carer experience is an expertise that we need to be respectful of, but also there are different niches in different areas within mental health, and we need to get really open about the discussion about what people want and how do we actually make sure that those people then align with what's happening? Because I think that's the most powerful and effective way of bringing the two together, and they need to be brought together, is my understanding and my experience.

In saying that, when there has been representation or consumer consultants, or any of those kind of views, there is the tendency to come in, have an hour meeting that they would maybe get paid for, and then talk about an issue and hope that any recommendations that go then upstream will then somehow be followed and written-in.

Why can't we actually allow consumers and carers to be paid as equal members of such a board or a peak body or organisation, to then actually say, "Okay, so this is the idea that you've got. We value your experience and your opinions. Let's assist you, or you assist us, in how we actually make that into policy and writing."

So rather than gaining the evidence from them in a silo fashion, why don't we get them around the same board table? Why do we have to employ them for an hour meeting and then they go home, and they don't know if their recommendations are actually considered or not. Why don't we make it so that yes, they've got recommendations and decisions, but actually, they follow it through with the board, with the directors, with executives, with organisational managers?

That would be my approach, because then it can't be tokenistic. If you are sitting on the same table and you are at the process from beginning to end, it can't be tokenistic; it is inclusive, it's collaborative, and everyone remains equal and works (indistinct) within. I don't know if we're actually at that point or if we've ever done that, and I could only really speak for WA.

So that would kind of be my suggestion, is can we actually work with organisations at that high level, to help them bridge the gap of understanding consumers and families how they work, and helping consumers and families understand how boards and organisations work, to make sure that administratively, and when we're creating these policies, these documents, these bodies and reports, that we can actually have a decision-making that threads all the way through. Does that make sense?

PROF KING: Yes, it does. That's good, thank you. You mentioned - sorry, I've gone right back to the beginning of your comments - the IPS programs, and you prefer them not being run through employment agencies. And I can see some of the issues that you raised.

And you prefer them being run through community health services, but I can also see issues with them being run through community health services in terms of that may not be the central mission, if I can put it that way, of that health service; that they may be orthogonal in some ways, as opposed to say, an employment agency which is aimed at getting people into work.

So should we actually be ruling out employment agencies as potentially tendering for IPS services, or is it more that the commissioning bodies need to be aware that anybody who puts in a tender will have a different background, different incentives, different issues?

MS GREEN: I think with IPS models specifically, you could have flexibility in it. See, when it works well, it works well at the local level, and very much other regional levels; it works well when it's in that community-based service within that community. So even with Perth metro, you know, your north metro is not going to be the same as your south metro, or your east metro; just as Geraldton is not going to be the same as Kimberley.

So if there is flexibility to work at the local level, that might work better. Or maybe, we need to get better at the whole IPS model in general and actually create a bit more of a structured platform to know how much it's working, if it's working, what works, and how do we replicate that? But all within a tailored community setting, and area-based service.

The reason why I said it would be great to embed it in the community mental health service is because there is already a little bit of I guess a culture shift, in terms of the community development officer positions and different positions that are trying to create links in the community and referrals and supports and services. Because yes, just from an outsider point of view, that community health service has seemed quite stretched, and so whatever links they can make with additional services is generally quite helpful.

So if you had someone like a community development officer that oversaw that, who's already got the links to other services and supports, it would make sense that that would fit within there, so not necessarily within the medical whole team, but within the clinic itself, floating around the teams and with the psychiatrist. That would be my preferred mode, just because of funding restrictions and the way sometimes not-for-profits change, regardless of whether it's an employment agency or not.

If, however, the phasing-out of the employment agencies with the IPS model would cause considerable concern, evaluation would definitely be my point forward in making sure that the models that we do have are working well, and that it's a little bit more broader scope, because I feel like it's a bit hit and miss at the moment and we don't really know why it's hit and miss, and what's working, what's not. So that would be my suggestion.

PROF KING: Okay. An?

MS TRAN: So a question around the advocacy service. Which type of advocacy service are you talking about? Is it - - -

MS GREEN: Sure. So WA had a mental health advocacy service.

MS TRAN: That's right, yes.

MS GREEN: So again, it was pretty well Perth metro, although I'm sure it's regional so it would be more a phone call from this end. But it actually doesn't matter which service it is; it could be any advocacy service: it could be a locally based advocacy service, or a national

one or a state one. The main thing is that we actually need to communicate to people in a way that while they're overwhelmed and frustrated and unwell and stressed, that we somehow communicate to them that it exists, no matter what it is that exists, just that it exists.

Because too often, I find a lot of workers then debrief after the fact and said, "Well, didn't anyone tell you that you could've accessed this service?" And I always get from my hearings around the ground, a resounding no. And that worries me a little bit, because we have an advocacy service, why aren't we utilising it, and why aren't we telling people in a way that they can understand and appreciate that it exists?

And I'd like to see that statewide, nationwide; regardless if there's a different body per region and per state, it doesn't matter, but the way we communicate it needs to actually be more explicit, and also more accessible for people to understand it and then link in with it.

MS TRAN: Yes. And you mentioned that you wanted that access to be, for example, you could have brochures in EDs and whatnot.

MS GREEN: Yes.

MS TRAN: Is that because the typical consumer would want - non-legal advocacy services would be usually in the hospital setting? Are there other, you know, settings that non-legal advocacy services could be better accessed, I guess?

MS GREEN: I think the difference is that for not-for-profit organisations community mental health services, there are routes to sort of raise your voice; I'm not necessarily saying it's always easy. But through things like feedback and complaints, and you know, people can speak to a manager or a team leader, their communication channels can be a lot easier for someone to actually take notice and respond quite quickly.

Unfortunately, with your in-patient facilities, because it is run like a hospital or emergency department, it is mainly focused on the physical care, the here and now, and they're not necessarily used to linking in with community agencies and services, and that pathway of communication, where we're looking after their emotional and social needs, not just the imminent physical ones.

So absolutely, generally what happens within advocacy services that I've experienced is that it's always within the main facilities, because at community level not-for-profit, there can be complaints, you know, people can ask to change workers and different things like that; we don't have anything like that in ED or in-patient because it is just its own system, its own unit. So that's where I think where we need it the most.

MS TRAN: Yes, thank you.

PROF KING: Thank you very much.

MS GREEN: Thank you.

PROF KING: And next we have Cathy. Hi, Ms Fox. So if you'd be able to just state your name, if you're representing an organisation, which organisation, and then if you'd like to make any opening comments.

MS FOX: Sure. Welcome, thank you for having me. I'm Cathy Fox. In between jobs at the moment. I also was part of the establishment of the Consumer and Carer Advisory Group for Midwest Mental Health; I also sit on the WA Country Health Mental Health executive board; I also do accreditations in hospitals as a consumer rep.

And I'm representing myself as a consumer here today, but I also speak from a vast knowledge of what the sector offers, what the gaps are from a consumer perspective. I could also go into a carer perspective, but I won't because I'll keep it limited to that. So that's who I am. I'm a mother of six children, one deceased, and 10 grandchildren, and probably growing, I hope. So there is my experience. And can I start with a short story?

PROF KING: Please.

MS FOX: So in my work life previously - because I am 60 now so I know the government wants me to work till 70, but currently I'm not - in my experience there were two young children, five and seven years of age, who witnessed their father hanging himself in their lounge room. The school, the local school, was fantastic and they called the school psychologist, who refused to come because it was beyond that psychologist's expertise, and they didn't feel confident to debrief the children.

So the school then rang Mental Health in Geraldton, and Geraldton said the CWMHS worker is on holidays, so they wouldn't come either. These children were deeply traumatised, as you can imagine. An NGO adult worker went and saw them with an Aboriginal liaison officer, who was also an adult worker; went to see these kids. Deeply traumatised. I actually went and saw these kids; very distressing to go and see the struggle this family was having.

Three months later, those children had not seen a clinician. I actually wrote to the Chief Psychiatrist with a complaint, Mental Health with a complaint, which is why I'm not on the exec board. That's what happens if you raise a complaint. Because the services in remote areas simply are not doing their job, and these kids were greatly missing out, and it just breaks my heart to see young children traumatised and suffering like that.

So I bring that story to you because I think it's a very important story, and it's what we're on about isn't it? It's about where is it falling short? Well, out in remote, that's where it's falling short.

I have a few other things to say.

PROF KING: Yes, please.

MS FOX: So although there is a need for crisis - can I just read it, is that all right?

PROF KING: Yes, please, that's fine.

MS FOX: So although there is a need for supporting crisis mental health work, if more preventative measures were invested in, then the need to support crisis might reduce; no-one knows for sure, as we have not yet invested widely in it.

Standard 5.1 of the Mental Health Standards says that the service develop strategies appropriate to the needs of its community, and promote mental health and address early intervention, and prevention of mental health problems. So there needs to be a responsive and sustainable partnering with consumers and carers and NGOs, which provides holistic support and care to those in need. And if we got in early, then there may never be a need.

One of the gaps here is that there is no private psychiatrists for the midwest, and mental health services here are already snowed-in with the severe and challenging clients that they have. The gap for those with chronic mental health psychiatric needs, with ongoing consultant needs, is just enormous.

So I see a psychiatrist, I see him once a month; I have to travel to Perth to see him. I have done a Skype visit with him, but it just is not the same. In order for me to go and see my psychiatrist, I have to either fly or drive, which is quite costly, and then I need to stay the night because I'm too tired to drive back the next day. It's extremely expensive to do that.

And so I'm not alone, and fortunately, I am financially secure so I can afford to do that. Now, there are plenty of people here in the midwest who have chronic mental health problems that need clinical support, who fall outside the gap of mental health services, and are unable to access a private psychiatrist because they simply don't have that kind of money.

Another problem alongside that is the lack of bulk billing GPs. So people avoid seeing their GP because they simply can't afford to go; it's about \$75 to go and see your GP, of which you get about, I think, 40 back. but if you're on a pension or Newstart, that's just not doable. Then there is the problem of paying for the scripts. A lot of mental health scripts are quite expensive, so if you're on a pension you just can't afford it.

In 9.4 of the Mental Health Standards, it establishes links with consumers, nominated primary healthcare providers, and that can't happen if they don't have one. So we really need some bulk billing GPs. People that need a second opinion have to travel to Perth, and very expensive. There is also no face-to-face counselling available here in the midwest for carers, so there is the phone counselling service that HelpingMinds provides, but there's nothing better than a face-to-face person that you can actually debrief on, that understands your problems.

There is disproportionate financial impact on those requiring mental healthcare, and that's because a lot of them are unable to work, but do not fit the bill for Midwest Mental Health services; in remote areas, it's even worse, with no way to access counselling of any sort without a phone, which many people in remote areas do not have, or don't have sufficient phone credit to allow for lengthy sessions with private practitioners.

And this is a major problem even in Geraldton, When I worked for Mission Australia, there were lots of my clients that didn't have phones. And the other thing with some people with

mental health problems is, they are very good at losing phones and things like that. So it's often a huge problem.

There is urgent need for mental health beds in Geraldton. I know we've got them coming but it's an urgent need now, as the risk of sending people via plane to Perth for treatment is very risky. Consumers must be significantly medicated to fly. So at 1.9 of the Mental Health Standards is the right of the consumer to be treated in the least restrictive environment, to the extent that it does not impose serious risk to the consumer or others. And I put it to you that sedating somebody to unconsciousness is a serious risk to their health and wellbeing.

And 7.7 of the Mental Health Standards - and I refer to them because I know them - that the mental health service considers the needs of carers in relation to the Aboriginal or Torres Strait Islander persons, and the culturally and linguistically diverse persons' religious, spiritual agenda, sexual orientation and socioeconomics. So these are all things that they need to consider.

A sideline to this is that if someone wants to access a mental health advocacy service, which my colleague talked about earlier, then this is only available by phone or Skype. People can't get a face-to-face meeting here in the midwest, with a mental health advocate, which is appalling, because we're not so tiny that we couldn't have one.

I know there are three cases where consumers were not given their legal rights of their paperwork prior to entering into the tribunal mentions; so as they were walking in, "Here's the paperwork." How can you represent yourself and defend yourself if you don't know what the charges are before you head into the court? So this is a huge problem that needs to be really be addressed.

There is also a need for crisis teams to work alongside and within the emergency support services. And I know of somebody whose wife rang and said their partner was suicidal, and he was walking down the street in a country town. And the police saw him, they put their sirens on, pulled up, handcuffed him, through him in the back of the car and drove him up to the hospital - so he's hugely embarrassed - only to be released 15 minutes later by the hospital, and this is really a lack of emergency services understanding how to work with somebody in crisis.

Education for all emergency services is what I'm recommending. Recovery-based education, definitely peer led, so consumer and carers delivering that training, because hearing that from those that are using the services will have a better impact and outcome.

Medicare rebates for holistic service providers such as art therapists, because a lot of people can't relate to going and talking to a counsellor, but get an enormous amount of benefit from somebody like an art therapist. Currently there's no Medicare rebate for that, so it would be good to consider that.

Dental costs are incredibly prohibitive and the mid west dental service is already overrun with people, and you can only see them if you have a health care card, and this leaves many people without the ability to afford appropriate dental care, and my own story is every time I

got a rotten tooth, which thanks to the medication I was on was quite often, my mental health would go through the roof and I would end up in hospital until that tooth was fixed.

So there's a definite link between bad teeth and poor mental health. So somehow the government needs to fund dental services so that people with mental health problems can get those - their teeth fixed, because that might be all they need to be well.

Dentistry education for children I think is important, because we really want to start young before they're adults, before their youth, before mental health begins, and teaching children how to clean their teeth and the importance of how it impacts the rest of your life is something that I never got as a child and would be I think hugely beneficial to children. I also think we should provide free toothbrushes to every child so that nobody misses out, because a lot of kids don't have toothbrushes because their parents don't have money to buy them or they have never learnt to clean their own teeth so they don't see why it's important.

There's a lot of children in the mid west who have food poverty, and I know this has already been spoken about by people, but food poverty is a major issue here throughout the mid west. So one way that I think this could be addressed is if all schools provided a hot lunch for kids no matter what their socioeconomic status is. So it's free, lunch is just part of the service. It might seem expensive, but providing good nutrition sustains mental health.

Getting people moving and exercising is very important. So I'm giving you the holistic viewpoint because that's what got me well was eating well, exercising well. So I wonder whether we can have some sort of program that provides young people in particular with some sort of funding so that they get the opportunity to engage in playing sports or art activities or music activities so that their minds are filled with healthy things rather than anxieties. So meaningful activity is shown to reduce the risk of addiction problems as well and has benefits of building healthy bodies.

We need a peer led and community supported drop in club of some sort for those who are lonely, somewhere people can stop and chat with friendly people, and this might reduce loneliness, depression and suicide. Men's Sheds are doing a great job across the country, but not everybody can join a Men's Shed.

The other - my last point is that it would be really great if we had free quit patches for people with mental health problems because 80 per cent of people that smoke have mental health problems. So it would be really good if the Quit campaign addressed that part of the campaign of the people with mental health problems. Providing patches might be a good beginning. I think that's it.

PROF KING: Thank you very much. I'd like to ask you some questions about a few of the areas. So with regards to both advocacy and psychiatry you mentioned phone, Skype and so on, which has its own limitations in terms of access, but I wonder if you - yes, face to face almost always is better. Not for every consumer, some consumers prefer the anonymity of online or prefer the anonymity of phone services, but of course we have a limited workforce both in advocacy and the clinical workforce and everywhere else, and with the large distances. Have you thought about other alternatives? So for example I know on Cape York there is visiting psychiatrist services, and I know there are different views about their

effectiveness, so I won't go into the details, but have you thought about whether - are there other programs that you've thought of or you're aware of that may sort of bridge that gap, so it's not face to face better than community, but it may also be rotating as something like that. Any thoughts?

MS FOX: My thoughts on rotating psychiatrists is that you wouldn't get a good service. You have to build a relationship, you have to know the person, they have to know you, although that would be better than nothing. Currently in the mid west we have visiting specialists of all sorts of different specialising areas that meet at St John of God, but psychiatry won't come, and it really is a huge shortfall.

PROF KING: By the way you?

MS FOX: So I need to see a psychiatrist at the moment and I have to go to Perth for it.

PROF KING: And going to Perth is - - -

MS FOX: And it means that - so I ran out of medication on Friday, but I'm not seeing him until Monday. So that meant I had to go to the GP to get that which cost me extra money and all I needed was the scripts. But I couldn't ring him in Perth and get them because it's all very complicated.

PROF KING: I will come to that in a second. By the way your comments on the problems with visiting psychiatrists were exactly the ones that have come up in Cape York. Maybe they should have asked you before they did Cape York because that was really good. Just on the pharmaceuticals and the bulk billing GPs. We haven't addressed it a great deal in this inquiry because there have been other inquiries including one I was involved with, although not a Productivity Commission inquiry, looking at pharmacy and scripts. How do you find the subsidy for the medicines, the safety net - I suspect a barrier at the moment with your psychiatrist in Perth is that formally you have to have a bit of paper. A script is a bit of paper in this country, it's not an electronic record, which hopefully is going to be changing fairly soon, but can you just expand your experience for example - I am not sure if you've reached the safety net or whether you're eligible for the subsidised medicines versus the standard co payment, but just your experience with the medicine system.

MS FOX: Well, years ago I was put on Lamotrigine before it was on the - - -

PROF KING: PBS.

MS FOX: - - - PBS, yes, and it was about - I think it was over \$100 a month unless you had a specific type of epilepsy, which I didn't have, but at that stage I was in hospital an awful lot and I was living in Canberra at the time, and the Prince of Wales, which was the mood disorder unit, recommended it. So the hospital in Canberra met and decided they would pay for the medication for me. So I picked - they kept me in that medication for about two years where I would just go in and collect it once a month, and at the time we had no money, so - you know, I wasn't working and we had a lot of kids. So that was a real blessing to our family. But that's what medications are like, a lot of the psychotropic drugs if you don't fall

into the right category you don't - you have to pay the extra money to have it. So if I was on a pension it's just completely prohibitive.

Currently I'm on an antidepressant which is \$75 a script, because it doesn't come under the PBS either. I take - I can't take the prescribed antipsychotic for me because it knocks me out for two or three days straight. So I'm on another one which is only available for people with schizophrenia, so again that costs me about \$80 a month. So if I was on the exact things for bipolar it would be like half that. So these are the things that people have to deal with, they have to make a decision as to whether they're going to forfeit something else to pay for their medications or take the ones that the government's already said works, even though they weren't working for me, and when I got on the right medications my health improved and I no longer needed hospital. So the government suddenly saved a whopping amount of money because I used to be in hospital a lot.

PROF KING: That's really interesting because it's something I will confess I hadn't thought of and I should have, but of course you can have medicines that are listed on the PBS, but unless you've got the actual diagnosis that matches up with the medicine you don't get the PBS subsidies.

MS FOX: That's right.

PROF KING: Which I can sort of understand physical health, but in mental health where - we've talked to people who have had five years five different diagnoses before they eventually get correctly diagnosed, and you sort of think, well does that mean you just fall through the gaps for five years because there isn't that match there. So thank you, that's something we hadn't thought of, and I think it's important. I've got a number here, but let me do one more before passing over to An. You mentioned beds, mental health beds in Geraldton Hospital. So we see a shortfall - so in our report you'll notice we see a shortfall in the acute hospital beds. We also see an even bigger shortfall in the subacute and in the community beds. So when you were saying that there's a shortfall in beds in Geraldton Hospital is it just the hospital, do you think it's broader than that, are you aware of what are the number of beds available outside the actual hospital setting?

MS FOX: Well, in Geraldton there's two allocated beds that psychiatry can use for a population of - I think there's about 60,000 in the mid west. I'm not sure, it could be 80. Someone will tell me. That's not very many beds, and the average - I don't know what the average stay is, but I had the distress of having somebody admitted who was extremely suicidal, an Aboriginal over the age of 50, who was only kept for two days, which is atrocious, and five days later he was dead. So I feel that we need the right - a greater number of beds and we need a greater number of bed stay days, so that somebody that is really suicidal can actually get some proper therapy and currently they can't. There's no step up/step down here yet. It is coming, but how many people are going to die whilst we're waiting for these essential services. Step up/step down is a brilliant thing for the community, but it's obviously quite a way away, and people are struggling now. So, you know, we need it.

PROF KING: Thank you. An?

MS TRAN: Just a question on - thank you for sharing first of all - so you spoke about a holistic approach towards recovery and I was interested in hearing about how - what helped you most in your journey towards recovery.

MS FOX: Thank you for asking that one. Can I just say that I'd been told by doctors I would never get better and my husband had been told pretend she's dead, and that way when she's in a good headspace you can celebrate and enjoy being together, and when she's not, well you won't be surprised. Great support there. So I went through a period of great deep mourning of who I had lost, and my identity was completely gone, I felt shame and all things just made my mental health worse, and one day somebody else got better in front of me and I thought she was a lot more crazy than me. So I thought if she could do that I could. So what was she doing. What she was doing was when she was having a bad day she'd just go to bed for the day and she'd be right for that. That didn't work for me because I can't go to bed for the day. I just can't do it.

So I needed to find what worked for me, and essentially what worked for me was exercise, and not just a little walk down the street, but profusely sweating exercise, eating a healthier diet, so I changed my diet, which by the way people can't afford a healthy diet because it's expensive, and I made a list of all the things I liked to do before I got sick and I determined that on the days that I was feeling really rotten I would force myself to do those things because that's what I used to enjoy doing, and I made a list of goals.

There's a scripture in the Bible that says people without a vision perish, and they do. You've got to have some goals, something you're working towards. So I wrote a never ending list of goals, so I add to it whenever I need to. It's astounding how you put a goal up there and it happens. We had no money. One of my goals was a hot air balloon ride. I went to school for my daughter's performance and one of her friend's father's was there and the principal was being really sweet to him, and I was standing there and he said, 'Yeah, I've got a hot air balloon', and the principal said, 'I wouldn't mind having a ride', and I went, 'No, take me.' Anyway he did. So, you know, that's how good writing a goal down is, that even though it's outside your ability to do it somehow things happen and you get those goals met.

Holistically, so I invested in reading books on what I could do to help myself. I read widely on other people with my diagnosis what they've done to get well, and I took the parts that worked for me. Everybody's different, so that won't work for everybody, but there is something that will work for that person. I think the number 1 is you've got to give yourself credit for where you're at that time and love yourself, and then start to look for what works. But having things like holistic care, so being able to access therapy, music therapy, that kind of thing, those things all help.

PROF KING: Thank you very much, and thank you as An said sharing your story with us, that's been fantastic.

MS FOX: It's a pleasure. Thank you for having me.

PROF KING: Next we have Leslie-Ann Conway. Thanks, Ms Conway, and if you would be able to state for the transcript your name, your organisation and if you'd like to make any opening comments.

MS CONWAY: My name is Leslie-Ann Conway. I represent the Geraldton Regional Aboriginal Medical Service, and I know there may have been acknowledgement which Elaine and I may have missed earlier, but I'd like to acknowledge other Aboriginal people in the room and certainly the (indistinct) and Yamaji people. I'm a (indistinct) Ballardong Noongar woman, I'm from the south west. I'm working off country. In a previous life I lived and worked in Kalgoorlie with an Aboriginal child and maternal health service known as (indistinct), which means many mothers and children, and I'd also like to pay respects at this particular point in time certainly to the Clark-Jones family who had recently lost a family member who was tragically shot by police, but it was well known that she had a number of mental health issues, and we know from supporting the family that in that whole situation the family had rung the police as first responders because they were unsure about how to help and they wanted aid to help their sister sort of in her sort of traumatised state about what they could do for her.

I suppose the basic premise my colleague and I have been talking about, the premise of this conversation is certainly around what we see as systemic failure for Aboriginal people in what it is around the fields of employment, health, justice and housing, and GRAMS deals daily with vulnerable people in trauma who are dealing with these types of systematic failures.

If I could just give a basic, a real story about Aboriginal people's world views. My brother most recently had open heart surgery and he was at a specialist centre in (indistinct) and there was an Aboriginal family, countrymen from the western desert - and this is just to give some clarity to a world view, because I know a lot of agencies here receive money for specific Indigenous services for our people here in the mid west Gascoyne region.

So getting back to the story what had happened was my brother was seeing the cardiologist and he'd gone up and down the lift a couple of times and he came down and he talked to the countrymen in the corner and he said, 'Would you like me to accompany you up to the lift? I've just finished my appointment do you want to go up?' And they said, 'We're not going in that machine', because they would see people going up and when the lift came down the person was different. So there was no way just in terms of access that those Aboriginal people were going to get into that machine to access the service that they needed to. So Simon said he took them and explained to them. So he spoke to the cardiologist and that was - that was the sort of situation that I think where you can - you can try and elicit from that story that whilst you might have the best intentions and have so much empathy you're still not Aboriginal, you don't share the same world view.

So I think it's quite significant when you look at situations where you have to take heed to the number of reports that have been done around Indigenous health, around Indigenous mental health, that services have to come to Aboriginal organisations to make a sense of what's going on in our world, and predominantly the Aboriginal community controlled health services that had been in good stead over the last 40-odd years prior to 1967 - sorry, post 1967 - the Aboriginal medical services have been around for a long, long time to be able to provide those appropriate services.

So just basically what I wanted to do was just to make a presentation, and you've probably heard this all before about our particular model, and if I could just read from this about what GRAMS does. So GRAMS is a community controlled organisation offering an affordable and culturally appropriate health services throughout the mid west, Gascoyne and Murchison community. So it's a huge - it's a huge geographical area which we struggle with, but then we take that on board as well, because of a nomadic and transient nature anyway is Aboriginal people, so travel isn't really off centre, and particularly I suppose I would say that to a lot of people who live rural and remote anyway.

So through resident and mobile services we work collaboratively with service providers to offer a range of comprehensive primary health care and mental health care programs. GRAMS believes in promoting healthy lifestyle, social and emotional wellbeing and early interventions. Our programs through GRAMS are embedded both in the tangible and intangible cultural frameworks around our own identity and spirit. These cultural frameworks are cognisant of the cradle to the grave approach, which encompasses the breadth and width of complexities within our Aboriginal populations throughout the mid west.

One of the programs I will speak of quite in depth is certainly our Maga Barndi Social and Emotional Wellbeing Support unit. Now, we try to deliver this program, or we do deliver this program and the AMSs work on a holistic model and we find that's best practice. We have a local - not local, a regional or a state peak body, which is known as the Aboriginal Health Council of WA, and of course there's a national peak body which is NACCHO. So they represent us on a more national and strategic level.

So certainly the Maga Barndi unit itself it consists of a social support coordinator, a social worker, psychologist, social health trainee worker and two Aboriginal mental health trainees. The team provides holistic and culturally appropriate social support services to support families and individuals in complex crisis. Counselling is available for adults and children for depression, anxiety, trauma, anger management and post-traumatic stress disorder.

Most recently GRAMS has initiated a number of grief and loss space support programs. We find that a lot of grief and loss and trauma is all that enter generation and it's across generations and we deal with them daily, and this is also to address the recent spate of suicides throughout the mid west as well and the complexities that affect families post suicide. We have an out of home care support group to families who have had their children taken into care, and we also work with families who have had their children removed. So there's two distinct groups there, who suffer trauma and mental illness and anxieties around this whole process.

We have a twilight blue men's support group to tackle men's depression. We have a youth alliance and leadership support group to assist young people and older youth to tackle their aspirations and the complexities associated with their own aspirations. More importantly GRAMS also in the grief and loss space we work and have an unfunded program for the last 35 years around returning our people to country. So what we do is we - if someone dies for whatever reason, whether or not it is through suicide, whether or not it's just through a normal morbidity where they may be (indistinct) in Perth, what GRAMS does is facilitate the return of people to country. I think the longest trip we did is we went from Geraldton to Port

Hedland, Port Hedland to Meekatharra for the burial and we came back to Geraldton, but that was to assist the family in terms of their own economic disparity.

So we take that cost off them and GRAMS wears that, but that's unfunded, we do that out of our own discretionary funding. But over 40 years I believe we brought 1,010 people back, 1,010 people back in the 40 years which equates to close to 25 people a year, which is one a fortnight. So therein lies its own statistics about what we need to do and what we continue to need to do.

So I do certainly agree with a lot of the comments that have been made by everyone that's presented here to the inquiry. We have a number of other programs and I'll go into them. We have bringing them home, which assists the stolen generation, families of the stolen generation, which are a particularly dying sort of breed of sorts, but what we find is obviously the enter generational sort of effect of that.

We have the family health unit which deals with our infants and youth from zero to 14; the chronic disease unit which is all other populations. We have a regional tobacco program, and I agree with what Cathy says about, you know, patches for people that are really stressed and what not. Yes, we have a program through - we have that sort of ability through our (indistinct) program. We have a more than medicine program where that's health and exercise and diet and everything else that we operate with. We have a relationship with (indistinct). We have student health nurses and doctors coming through GRAMS and our Centre of Excellence, and we have an integrated team care program.

So whilst we have a lot of resources we are still seeing ourselves as under-resourced. Most recently we've been funded through the Western Australian Primary Health Alliance and I believe you have a copy of this of our most recent suicide prevention project, and in that particular project what we found quite damning for ourselves in terms of the services that are meant to be provided to Aboriginal people, what people were saying and which is reflected through Alastair Hope's coroner's report from the Kimberleys in 2008, the Royal Commission into deaths in custody in 1991, and Ros Fogliani's most recent report as well of the death of the children in the Kimberley, they were saying the same things, that Aboriginal people are not accessing the services.

So how much does it take for Government to realise that there needs to be more recognition? I mean, most certainly with the devolvement and the abolition of ATSIC in 2006 and I've worked with them, and Indigenous specific funding going mainstream, that certainly opened up.

MS TRAN: Yes.

MS CONWAY: Let's say a lot of the faith-based organisations with the best intentions and you believe that there is sometimes that whole preservation of thinking around, well, from an Aboriginal perspective, about people still think they know what is best for us. So that puts us in another position about us being credible enough to stand up and I believe – and I'll leave a copy of these with you – is when Debbie Woods and Sandy Davies, most recently, had made a statement to say that they were calling on both the State and Commonwealth to support peak health services for Aboriginal people and providing two full time psychologists and at

least six full time mental health practitioners, and if combined, the State and the Commonwealth could provide long overdue rudimentary mental health needs for the forgotten and neglected Yamatji people. Four full time psychologists and at least four full time Aboriginal mental health practitioners.

So it was reported most recently, and I don't want to regurgitate lots of stuff that has been said so far, but we'll state here and it has been stated, that in 2019 stand-alone, (indistinct) Yamatji people are tragically the nation's highest suicide rate with more times the suicide rate of the (indistinct) First Nations people.

So when you take all of that on board, holistically, what's happening out there in the community and with Amy in the room, I must, too, be thankful that stage 2 of our suicide prevention report has been funded. And I briefly discussed this with Amy because I said I would make reference to it. So initially when GRAMS made funding for an elevated amount of money which was close to \$700,000, but that negotiation had been reduced to a lot less than that. So what we thought from a very critical level, we thought are we being thumb-nailed and screwed over again? Because we're being given a reduced amount of funding to do a more of an area. So we're doing three locations, so in terms of scales of economy, certainly you would wonder about how relevant that would be about the delivery of what it is that we do for our people.

But certainly in my conversations with Alistair earlier this week around the enquiry and the hearing, it was that we needed to have the voice of our people heard and it was as I mentioned, where we talked about having no credit on your phone to have access to just call someone and to know that someone is there and you are not alone. Little things like that mean a lot to people. So GRAMS in itself, what we do is that we provide a lot of self-help and management. We have the long intensive care and certainly the moderate intensive care – intensity care, which we give to our clients. And I will say that in our more remote communities, in particular, our outreach clinic in Mount Magnet and I'm not sure about Carnarvon, but I know in Mount Magnet it's 48 per cent are non-Indigenous clients. So, again, you wonder to yourself if they're, it – you know, how well do we service the whole of the community. And phase 2, I might add, we'll be going into community action plans, because what we believe is that services can be funded forever and a day and services can visit forever and a day, but how do you make it sustainable within community for them to be in charge of their own health destiny and their own well-being.

So hopefully, that's what phase 2 will focus in on. In the locations I mentioned, Mount Magnet, Geraldton and Carnarvon. But I don't think we really wanted to mention anything else. I know that we did talk about wanting to say that also the premise of we think that – and my colleague works in the Maga Barndi unit where we're dealing daily with people who are affected by abject poverty, food security and insecurity and we think to ourselves that possibly more of those models could be integrated because we're working with Thirrili, who won the National Indigenous Crisis Response Unit. We're also working with Jerry Georgiadis around the National Trauma Response and Recovery Project which enables us to say, well, if you need \$300 for food and \$200 for petrol, then on the spot we're able to provide that service through having those links and networks. Certainly GRAMS bucket is getting drier and drier but that's why we rely on other strong partnerships.

We certainly think that these systems of failure are relative to basic human rights of everyone which is around food, water and shelter and more often than not, when people are coming to us, it is around the issues of those three basic rights of food, water and shelter. The first thing they ask when they come in to see anyone is can I have a cup of tea or is there a bottle of water because it's – whatever, they need whatever. So we wonder about those sorts of premise, those sorts of systems and how they continue to disadvantage our people. And certainly in terms of what we believe is – with – my colleague has worked quite closely with Harry Blagg from Western Australia. And he's done a lot of work around family and domestic violence. And we believe that in terms of his opinions around the three deterrents of vulnerable people and more particularly Aboriginal people about accessing and reporting crisis is that there is fear of removal of the children. There is only services off-country, which means you're being removed from country. And that certainly there's fear of retribution or incarceration. So those are probably the three main sort of reasons that when we unpack our daily work load of what it is that we do with our clients, that one or two or three of those will be quite prominent in people's reasons why they don't go to other services as well.

So yes, GRAMS will, in the offing be presenting and doing a more in-depth response to the submission – to the inquiry and have a formal submission prior to January 2020. But in saying that, I would also like to say that I agree totally with all the recommendations that were done with the Indigenous evaluation strategy where the Institute for Urban Indigenous Health made a submission about what it is that we need to do in terms of evaluation funding and all sorts of different things about how to make the world a bit of a better place for not only Aboriginal people but all our vulnerable people. And other citizens as well. So yes.

PROF KING: Thank you.

MS CONWAY: Thank you.

PROF KING: So, if I can ask a few questions. So in our draft report, we recommended draft recommendation that for suicide services provided to Aboriginal and Torres Strait Islander peoples, that the preferred providers should be Indigenous controlled organisations.

MS CONWAY: Yes.

PROF KING: So I'd be very keen to get your feedback on that recommendation. In particular, and we had a debate and we recognise we're not Indigenous people and so we want to make sure that we're talking to the people who will be effected by our recommendations, that we've got it right. So we said Indigenous controlled organisations rather than the (indistinct) for example, and I'd like feedback on is that right? Are we moving in the right direction there? We'd limited it to the suicide services. We had a significant debate internally on whether we should be going further. But we thought we should go back and get more advice. So I would ask your advice on should we be thinking much more broadly. We did also want to get advice on the mix of services, so the fact that there are Indigenous controlled organisations providing services to Indigenous Australians does not mean that there are not also the mainstream services that can be accessed by the Indigenous Australians.

And I'd also – so feedback on that – sorry, so let me stop it. So I've given you three things initially, yes.

MS CONWAY: So, well, I'm currently involved on behalf of GRAMS in an Aboriginal community controlled organised (indistinct) strategy which has been developed by the Department of Communities. So we won't go there with the Department of Communities and what's happening at the moment.

PROF KING: All right. Fair enough.

MS CONWAY: But yes, most certainly, we think to ourselves well, this is my own opinion because I've been a public servant as well as not-for-profit for the last 18 years. But certainly, you think to yourself the whole thought around co-design and co-production, I think there's a relevant space for that to happen. It can't just be a word and a tool. There has to be real integration of thought and what that model would actually look like. I know that I'm also involved and have been involved with the Department of Finance on a number of strategies around procurement and tendering. And I think sometimes even those methods of procurement and tendering, sometimes put Aboriginal organisations on the back foot when you're looking at an ACCO not an ACCHS.

So if you're looking at just a community controlled organisation but not necessarily a health service, so then you wonder and this is what the whole ACCO strategy's about at the moment. How do we ensure capability as well as capacity and we're saying, well, my argument is well, the ACCHS are already in that space. So how could you combine the ACCOs and their lack of capability or capacity with organisations say like headspace or with HelpingMinds or whatever the case might be. How could you integrate a really good service model and even in terms of the procurement and tendering, those – it must be even more so to find a detail, do you know what I mean?

PROF KING: Yes.

MS CONWAY: So it's not that, oh, GRAMS is going to provide the transport and the sausages and you know, headspace will provide the clinical side. There has to be a real conversation, an authentic conversation if I can say, around those sorts of pliable sorts of terms and elements in a contract and how you would work through that. But that's just one basic element of the whole conversations.

PROF KING: Yes.

MS CONWAY: So the other – I hope that may have answered some of your question.

PROF KING: Yes.

MS CONWAY: The second part that you wanted me to talk about was - - -

PROF KING: So – well, actually, just before we go onto that. So from that can I say so in a sense to get that conversation, do we need the Aboriginal Community Controlled Organisation in the sense it's got to be the centre of the service delivery model. So rather

than saying, you know, we want these services for an Indigenous community and yes, well, there can be a model put together that has some Indigenous representation or some – say, involvement of an ACCO in it, do we need to go further - this is from your answer – and say the Indigenous organisation, the ACCO or Aboriginal Community Controlled Organisation has to be the central element in the conversation that has to be around that element. Am I getting it right or not?

MS CONWAY: Yes, I think so. But I think for so long, Aboriginal people have been on the peripheral and the inclusivity or the word inclusivity is a word. So people who actually want to include you for a genuine purpose will include you.

PROF KING: Yes.

MS CONWAY: And I think that's why we stand back a lot because there's not a lot of trust because of the systems of the systematic screwing of us for so long. So you sit on the outer until you sit, well, what's going to be pleasurable to us or what's going to help us achieve our aspirations.

PROF KING: Yes.

MS CONWAY: And I will say with Amy in the room, certainly with West Australian Primary Health Alliance, in stage 1, we had a lot of flexibility around our reporting in terms of the timeliness of our reporting. There was a huge lot of flexibility which allow for the way that we delivered the project and the way that we worked as two old bush chooks, what we did out there. And how we best work with community. And I will say that certainly phase 2 and there will be an evaluation, because the mid-west is a trial site. And I know that there's going to be an evaluation by the University of Melbourne in March and whilst we're taking that into account with the suicide prevention project what's happened is with stage 2 funding which is sort of unheard of but not really, and we understand that representatives of WAPHA have sort of gone into bat with the Commonwealth.

Now, they're allowing us to go right through to December 2020. So not only the contract period when I believe that will be completed, the suicide prevention – that trial will be ended in 2020, but they're going to allow us to go through to December 2020. So something like that, just pure and simple understanding of how we needed that time.

PROF KING: Yes.

MS CONWAY: That whole time to do what we needed to do with community and other service providers, and users and certainly those that are, yeah, it just makes sense and we're glad that is has made sense and we're glad that it's going through to December 2020. So we've literally got 14 months for the program. We're initially, but again, getting back to the scales of economy, three locations, less of money than we ask for, so maybe that's sort of the buy-off. So yeah.

PROF KING: How broadly should we go? So the second part, I think I mentioned, was how broadly should we go? So should it be – so we – rather than just suicide services, should

it be that Indigenous controlled organisations should be at the centre of all mental health services provided – sorry – it’s a wrong way of putting it.

Indigenous controlled organisations should be central to all mental health services provided or available to Indigenous Australians. Not necessarily provided to, because there are still mainstream options and the individual can choose.

MS CONWAY: Of course, of course

PROF KING: So should we go further? And if so, I mean, is that practical? Are we starting to get into clinical areas for example where there may not be an Indigenous workforce? I’m not sure about the practicalities of how far we take this.

MS CONWAY: I think again, getting back to that co-design and co-production. I think that you could find, I think, my own opinion is that there could be a workable model if you could get people that were willing, as I said, to have those authentic conversations, a bit like the Stephanie Alexander shared table stuff, ‘what do you bring to this table?’

PROF KING: Yes.

MS CONWAY: So you know, I think those sorts of things need to be had and resources and money can happen once that happens.

PROF KING: Yes.

MS CONWAY: But who ensures that that happens? Is it WAPHA? Is it the Commonwealth? Is it Western Australia? Because we’re predominantly funded through State Health and Commonwealth Health.

PROF KING: Yes.

MS CONWAY: So who does that? Is it the procurement and tendering service? We’ve talked with the department of finance about having pre-engagement conversations. Even prior to you putting in a tendering, do you need to have that – you can have a tick box. We call it the black tick box. Yes, we’ve got a partnership with GRAMS. Oh, yes, I spoke to (indistinct) twice on the phone last week. So therein lies someone will say we’ve got a partnership with GRAMS. Well, no, you actually haven’t.

PROF KING: No, you don’t. Yes.

MS CONWAY: But for people who are looking already at a tender, then they’ll say, well, you know, they’ve got a partnership or there is a perceived partnership which they perceive and imply in their tender, but it is on the ground not a relationship. So therein lies my issue about do we need to look at those processes or pre-engagement or pre-engagement to tenders.

PROF KING: Yes.

MS CONWAY: And who drives that? Department of Finance? Whoever the department might be, who's seeking the service from within community. So for me there's a lot of validity around that. And it brings a bit of – yeah, and it would allow for the space to be open enough for people to be quite honest with each other without any trump cards hopefully.

PROF KING: Yes, no, that's really – that's a really good point that the issue is, yes, who's responsible for making sure - - -

MS CONWAY: For that.

PROF KING: Yes.

MS CONWAY: And it's the accountability stuff which is where Ben Wyatt had alluded at some stage the Western Australian Aboriginal Advisory Council maybe devolved in terms of thoughts around an accountability of permission, were they talking about? To making services responsible for their delivery and how accountable and how productive and possibly even the social impact measures. And I think that's a really important conversation to have around changed behaviours as well, about how important that would be when you're looking at whether or not a service was providing accountable services for Indigenous Australians. So – and other vulnerable people. Yes.

MS TRAN: A question around local initiatives.

MS CONWAY: Yes.

MS TRAN: And whether or not there are any of that link, people with mental illness who come to you to other, I guess, provide social determinate such as legal services.

MS CONWAY: Yes.

MS TRAN: Is that - - -

MS CONWAY: So what happens with us, our created pathway in the organisation is that we have referral systems off – that we – if we can't deal with the situation ourselves, which is normally what a lot of Aboriginal people will do, when people look at aged care services, oh, why don't aged care services want to – are coming into you know, having an aged care package, why aren't they – well, rah, rah, rah.

Aboriginal people tend to look after their own. And will take that on board hence over-crowding and other situations. So what we predominantly do at GRAMS through our Maga Barndi unit and how we support people is that we try and do it ourselves and then the pathway will go to outside services if need be. Legal services. Now, just really briefly, and for instance now, through Megan Krakouer, the boy that committed suicide here in the mid-west to two, three years ago, the 11 year old? Yes, the 11 year old boy? His brother - - -

UNIDENTIFIED SPEAKER: Brother.

MS CONWAY: Brother? His brother has recently been supported by an Aboriginal group called Ngalla Maya so we're – we met with the mother and the brother and other family members. They'd never accessed any other services after that boy's suicide. And what had happened was, they were in financial crisis three years down the track and what happened was we ferried him off quite gently with an Aboriginal worker from the Trauma and Recovery Project. Escorted him to Perth and got him into a pre-employment program and he's got all his tickets with the mines and is now working on the mines, the brother is.

But what happened was, if he hadn't have accessed our group therapy through the suicide support group that we have, then there's no way he would probably still be out there in financial crisis with the family. So that's what we do. We try and deal with – I suppose you can look at the Maga Barndi unit as the head of the octopus and then all the other tentacles there, they're the supports that we seek if we have to. Because more often than not, and we shouldn't have to, it's like a – I've talked to Amy and her colleagues as well, that sometimes because Aboriginal people have been – and services have been so used to be – so used to providing services on so little money, the shortfall is nothing, whereas maybe we should share as well and recognise that there's other service providers who would willingly be able to, you know, help the head of the octopus with its tentacles. So yes.

MS TRAN: Also, so in the report, we have a justice chapter as well.

MS CONWAY: Yes.

MS TRAN: So I was going to ask, do you work at all with people in correctional facilities?

MS CONWAY: I know that most recently, last year – last year or the year before GRAMS used to run the prisoner health program and we ran that for a number of years. We're currently moving into a social justice arm of GRAMS in our holistic sort of vision, but certainly we had the prisoner (indistinct) prisoner program. But the State for their better way or thinking had pulled all the funding from the two most successful Aboriginal prisoner health programs which I believe was Kalgoorlie and Geraldton, so pulled them and so everything went back to it being a state run program as opposed to a localised program which GRAMS had. We could have hung a lot of hats on that accolade they'd say. But yes, so the program was taken from us.

So, and this is what I mean about successful programs are continually, yes, on – so you wonder about whether or not the state wants the kudos from what's happening locally in the region.

MS TRAN: One more question. You spoke earlier about services needing to go towards Aboriginal and Torres Strait Islander people

MS CONWAY: Yes.

MS TRAN: But they aren't always accessing the services?

MS CONWAY: Yes.

MS TRAN: I guess my question is around how can we improve that act - - -

MS CONWAY: Engagement?

MS TRAN: Engagement and that access.

MS CONWAY: I know that most recently, I've spoken to Debbie about – that's our CEO, I've spoken to Debbie about the way that we engage with people ourselves and it – most recently we – yes, I think sometimes you have to take the theoretical approach and marry it up with what it is you actually do. Which is what GRAMS is doing (indistinct) moment, which is why I'm the community engagement coordinator, so across levels, how do you imbed that engagement? But I mean, I know certainly for other service providers, who may have Aboriginal people working with them, they're still representative of that group, do you know what I mean?

Just a quick example, I know that when I was working in the Goldfields and we had emergency relief as a program for people in crisis, Aboriginal and non-Aboriginal. And there were about eight service providers. And the conversation from FaCSIA I believe that at one stage, they were taking all emergency relief funding and giving it to one agency, the Red Cross.

So I said, what tipped me was that the head of the Red Cross at the time. So there was that conversation around – if you give it to one agency, which makes sense in terms of consolidated reporting and consolidated budgets. You think there's sense to that and my public service head tells me, that's why it makes sense. But anyway, that's a whole other conversation. But when you have agencies who are delivering services to - specifically to Indigenous people and who aren't doing what they're meant to be doing, and I have had a couple of service providers who have said 'We struggle with the partnership and the engagement. Well, our argument then is, well, previous to you putting in the tender, then mate, that should have happened. But where do we go to from here? Because you can't sort of dwell on something like that and it's how do you move forward and how do you put those steps in place.

So certainly, the methods of engagement, the design and the delivery of engagement. Even from Aboriginal services, I think, that needs to be looked at. Almost like a comms model. You know, taking into account how you actually communicate with people. I know there's the unsaid and the said with Aboriginal people, but certainly about how we help our non-Indigenous brothers and sisters and service providers to actually become part of our cultural framework and learn some of the more intimate secrets about engagement and what it is that we do for Aboriginal people. So yes. I hope that's answered your question.

MS TRAN: No, it has, thank you.

PROF KING: Thank you very much.

MS CONWAY: Thank you very much. And thanks for the opportunity.

PROF KING: Thank you. I will look towards Alistair. Has anyone said that they'd - - -

UNIDENTIFIED SPEAKER: (Indistinct).

PROF KING: I'll ask generally. So is there anyone else who would like to speak?

UNIDENTIFIED SPEAKER: Could I just add a comment?

PROF KING: Please come back. You'll need to restate name and – again, because it's all for transcript.

UNIDENTIFIED SPEAKER: (Indistinct words).

MS GREEN: So Claire Green from Elucidate, just a brief comment. So I think what stands out for me today being the two key themes is (1) that we need to do better in our training within our clinical models because what I'm hearing is that we're actually just talking about communicating with people and it doesn't matter what group of people we're talking about. Actually, a lot of the strategies for working with Indigenous people actually work far better with the average white person as well. And so I think in our training when we're talking about our models, we actually need to get down to how do we communicate? How do we foster relationships within services? And how do we get there on a person based level, so we can talk about person based care, but yes, we're all still saying that it doesn't really exist and that we need to build upon it in the wider sector and the wider system level. So I think that's really important that we get to that grassroots issue.

And the second, which actually Cathy brought up, I believe, is that we also need to address the elephant in the room and that in clinical models, sometimes diagnoses are stigmatised over other diagnoses and that sometimes suicides occur because it's not because people haven't said anything, but because the right people haven't listened and haven't fully understood what's actually needed. And I see that more in inpatient services where people are being discharged, not followed up and when they're stating and when carers are saying that there's actually a clear suicide risk and yet where still somehow happy as a system to let them go home and to balance that risk from a home environment setting and I just know of, in professional settings, where, because someone has got a particular diagnosis, a suicidal ideation has not been believed or substantiated all because they're stigmatised as a particular group of people or within a particular setting and I think that really needs to be clear on the table that we need the relational issues sorted above and beyond any extra system developments, so yes, just wanted to say that.

PROF KING: Thank you. Any other comments? Questions? People who wish to speak? One more? Yes? Again, you have to come down the front though to form - - -

MS STEWART: Fiona Stewart, just a point - I wanted to follow up on the other Commissioner's question to me if there's time?

PROF KING: Yes, please come down and again, you'll have to restate names on for the transcript.

MS STEWART: Fiona Stewart, headspace manager, Geraldton. The Commissioner on the phone had posed a question around what we were doing with Clontarf because I'd mentioned that as one of our programs under suicide prevention particularly for our community and there's a long segue into how it came about.

But what it was, was the long format relationships that needed to be built with those young men and Clontarf is – and we identified Champion Bay High School at the time, it was John Willcock High School as being inaccessible to the main part of town public transport system. How do you find – we'll go to the young people.

And in communicating with a whole lot of informed Aboriginal and Torres Strait Islander men in the community, Clontarf was put onto my radar as a seven years ago Victorian, we don't have Clontarf over there. Our three male clinicians, we began trialling one year with a clinician who attended every core meeting that that year seven cohort of young boys has. Every camp that they go on, every health day that they have and their meetings.

And it was – all it was to begin with was the consistent same person there, every single time. Mental health wasn't mentioned and in fact I instructed them not to mention that. And that relationship over a year was evaluated with the head of the Clontarf Academy and he said yes, I want it back. And I said, do you want another one? Year 8? Because I have seen the Steiner School system slightly and when you follow a cohort of people through and so our first clinician is now in Year 9 with his set of Clontarf boys and he said to me, 'Do you think I'll graduate with them?' And I said, 'If you're here, yeah, definitely. On my books, you'll graduate with them.' They go to their ceremonies, so we have a clinician in Year 8 and our third clinician will start in Year 9, so there'll be a continuous presence of our – and they're male.

Had to be male clinicians, will go through with those young fellows and repeat exactly what's happened with our first one and in the meeting I had this week with Justin Mallard and Bob from Clontarf, Justin, the head of the academy said to me, 'Fiona, you said you'd be there' – I think, not Fiona, but the odd – you know, you've done it, you've turned up, your staff have been there and we're seeing those rewards now. And I knew it would take years. I knew it would take years and the hope is, that you can't put a KPI on at all, is those young men will have seen Reto who is the first clinician through to Year 11 or 12. If something happens where it's really – the straw that breaks the camel's back and it's impulsive, because part of the view around suicide is there was an impulsive nature.

PROF KING: Impulsive, yes.

MS STEWART: They will stop, potentially have the skills, because mental health is mentioned and good health and yarning happens now that they know Reto after two years going into a third year, that they might pause and say – they might not have to come to headspace. I don't mind about that. But there are people who will listen. There's a possibility and so that support is a part of a default mechanism, is the hope, but it takes that overarching relationship and I just wanted that Commissioner to know.

PROF KING: I agree. Thank you very much. Can I thank you all for attending today? Thank you, in particular people who have come from some distance here. Some of you have

come from Perth, some of you have come from other parts of the mid-west. I will – and thank you to the staff as well. Thank you to the transcriber.

I will now adjourn the hearing. Formally, we will start again in Perth tomorrow if you haven't had enough and wish to join us.

MS ABRAMSON: Thank you. Thanks, everyone.

PROF KING: Thanks, Joy. Thank you.

MS ABRAMSON: Thanks.

**MATTER ADJOURNED UNTIL
THURSDAY 21 NOVEMBER**