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PUBLIC HEARING INTO MENTAL HEALTH

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

TRANSCRIPT OF PROCEEDINGS

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PROF KING: Good morning. Welcome to the public hearings for the Productivity Commission Inquiry into Mental Health. My name is Stephen King and I'm the presiding Commissioner on this inquiry. My fellow commissioners are Julie Abramson and Harvey Whiteford. I would like to begin by acknowledging the traditional custodians upon the land on which we meet today: the Gadigal people of the Eora Nation. And I would also like to pay my respects to elders past and present.

The inquiry started with a reference from the Australian Government in November 2018. We have talked to representatives from the Australian State and Tertiary Governments, service providers and (indistinct) unions, academic researchers and individuals with an interest in the issues and (indistinct words) throughout the inquiry. We've released issues papers in an issue paper in January and have talked with a range of organisations and individuals with an interest in the issues. We've received 573 submissions since we started the inquiry.

We're grateful to all the organisations and individuals that have taken the time to prepare submissions and who appear at these hearings. A few weeks ago, we published our draft report and the purpose of these hearings is to provide an opportunity for interested parties to provide comments and feedback on the draft report, facilitate public scrutiny of the Commission's work and to get feedback.

We would like to conduct all hearings in a reasonably informal matter. But I do remind participants that a full transcript is being taken. For this reason, comments from the floor cannot be taken, but at the end of the day's proceedings, Ms Abramson will provide an opportunity for anyone who wishes to do so, to make a brief presentation. This is the sixth public hearing for this inquiry following hearings held around Australia. And we're going on from here to Broken Hill, Rockhampton, Brisbane, Launceston and Adelaide.

We'll be working towards completing a final report, and having considered all the evidence presented at the hearings and in submissions as well as a way of informing discussions. For those planning lodge a public submission with their feedback on the inquiry, the closing date for submissions is 23 January 2020. And the final report will be submitted to the Australian Government in May.

Participants and those who have registered their interest in the inquiry will be advised when the final report is released by Government which may be up to 25 parliamentary sitting days after completion. Participants are not required to take an oath but are required under the Productivity Commissions Act to be truthful in their remarks. Participants are welcome to comment on issues that are raised in other submissions.

These proceedings will be live-streamed to the Commission's YouTube webpage. All participants who have registered here have confirmed their understanding that they may be visible or audible online. If anyone here has queries about this but does not wish to be visible or audible online, please approach one of our inquiry team members here today or feel free to leave here and now.

The transcript will be made available to participants and will be available on the Commission website within a week of this hearing. Submissions are also available on the website. For any media representatives attending today, some general rules apply. Please see one of our staff

for a hand out which explains the rules. If you do wish to speak, by the way, at the end of the day, and you're not down formally to talk, please let the staff know during the course of today so we can organise that. Participants should be aware that any media representatives may be using Twitter and other internet mechanisms to convey information (indistinct) in real time, including participant's remarks.

We comply with the requirements of the Commonwealth Occupational Health and Safety Legislation. You are advised that in the unlikely event of an emergency requirement evacuation from this building, there will be relevant alarms. I did have them explained to me by Henry who's up the back. And I won't say but it's – 'Woo, woo, woo', and then 'This is not a drill'. And perhaps, though we don't need to really be worried, there are escapes – exits over on the side there and out to the way that you came in. The evacuation point is in Hyde Park near St James Station.

If you are at any time feeling distressed we have psychological support on hand and Lynne, would you be able to – if there's any additional information that you'd like to convey, we have team members here who are happy to talk with you.

How we like to do these presentations or the hearings is if we have say, five minutes for an opening remarks or opening remarks from participants and then we will have question and answer and a bit of a discussion to try and get the key issues. We will often welcome parties to put in their submissions, particularly where, you, know, given time limitations and further hearings, we can't cover often all the issues that we'd like to discuss.

So that being said, I would now like to welcome our first participants today, Patricia and Andrew Anderson. Join us at the front table. And formally, for the transcript if you could state your names, if you are representation any organisation, relevant organisation or capacity in which you're here in and then if you have any other remarks, we'd like to hear them.

MS ANDERSON: I'm Patricia Anderson. We're here as parents (indistinct) minimal service and (indistinct) experience. So we had an – the issues that arose as a result of that.

MR ANDERSON: Yes, I'm – pardon me. I'm Andrew Anderson representing the patient's father.

PROF KING: And are there any opening comments you wish to make?

MR ANDERSON: Pardon?

PROF KING: And are there any opening comments that you'd like to make?

MS ANDERSON: What we'd like to say, that we hope that what – what we do discuss here today doesn't have a detrimental effect upon our – having our child here, because we still are entrenched in the system. The issues have been – we have – we were looking into this situation – well, we tried to obtain help for our son and unfortunately we went through the public system and private system, back to the public system and a path (indistinct) lead to corrections and now justice health, through that pathway. Recognised that there were issues that we thought led us to being – fall through the cracks.

And they're things that we think that need to be addressed at this Commission. The initial response that we had with a product – with the mental health tribunal after our child was admitted to an accredited institution, we weren't actually informed on what the tribunal actually involved and what our rights were.

The fact that our child was an adult, was used as a tool against us and that the decisions that he was making were actually led to him not making the best decisions in his (indistinct) also for ours. The Mental Health Act requires that the patients have agreed to treatment, but if you've got a person that you're caring for, obviously as parents, then we – we needed to convince the treating team (indistinct words) hospital that these decisions weren't made and that we did have the interests of our child in our best interest.

On the start of our journey we found access to the system quite difficult, going through a GP which meant another appointment and when you have somebody that doesn't believe they're ill, that's just another obstacle to counteract.

We ended up – to get help for our child, we ended up calling the police and ambulance and they responded appropriately and took us to the services that we thought that we thought that we would get the best treatment from for our son. Unfortunately, the nurses advocating in that service didn't actually happen, so we didn't feel that we were represented through the nursing system rather than the mental health system.

(Indistinct) obviously our child was discharged from that after a tribunal meeting and then we needed a readmission. We feel as parents, we – that should've been a red flag. That obviously a re-representation to a facility should have had some sort of significance and initiative about a response.

Unfortunately, our circumstances involved in an altercation that required assistance from police and ambulance in the early hours of the morning. And the first responders were good from our first call to them to their offering us assistance was eight minutes, which is a fantastic effort and we are obviously are indebted to those people, we need to protect those people so they aren't in any danger for actually helping. Following that, we ended up in corrections where our son's comorbidities – being a Type 1 diabetic, we didn't feel were addressed at that time, which leads to further ongoing issues once he is actually in the list.

So I think early intervention (indistinct words) is appropriate in the treatment setting and would show a more favourable outcome to the person themselves and the community as whole.

MR ANDERSON: Thank you. I'll be able to cover the points that Trish hasn't. Just so the Commission can get a bit of an – a better overview of her situation and we consider ourselves a completely normal family, three children, (indistinct) the kids doing very well at school, although Rich let's – in 2012 our son started to experience depression. He sought the help of a private psychologist and psychiatrist. He put him on medication. There were some improvements that his depression continued and he was recommended by the psychiatrist that he leave school at the beginning of year 12 which he did. And then we helped him get a job. So the next year or two was fine. He did discontinue his medication in that period and in the

middle of 2015, when he was (indistinct) out of home of his own volition, he got caught up with the wrong people.

And then in the – sorry – in October we found out he was using Ice and then in November, 5 November, we sought the help of police and ambulance to get him into high school. He was transferred to Bungarribee House, an acute care facility. In there, the first couple of days, he was mute, he couldn't even speak. We were communicating by drawings. He seen him drew, they put him on medication. About a week into that first day, we realised that his partner was bringing him home cooked muffins and we believe they contained Ice. We complained about it. They said it was permitted to bring him external food.

Now, the facility is a secure environment and I think to be fair to the treating team, there should be no food taken into a secure environment because it's interfering with that environment. They're losing some control. So you know, taking food into a premises like that should be banned in our, you know.

Moving on, David continued to improve. On his 13th day in there, there was a family meeting and when we arrived, the psychiatrist and the team had already met with David and then he met with us. And the psychologist said that he was going to recommend that he be discharged. And we were taken (indistinct) to that. Because we knew he needed longer. He wasn't ready to be discharged and so then the meeting was combined with David, his treating team and us. And he informed David in front of us he would recommend to the tribunal that he be discharged the following day. Really, as I said, we were totally opposed to that. We argued vigorously against it and I actually know (indistinct words) wanted to be discharged, so that was the beginning of the (indistinct) between our son and our self because he wasn't getting what he wanted.

So the tribunal happened on the following day, all the handwritten reports were – could be read by anybody. The Commissioner requested reports of the following day, we don't know what happened then. But he was discharged. David immediately stopped his medication on discharge and (indistinct) 212 days after the discharge which was 11 December, I got him back to a (indistinct) appointment. Without me taking, he wouldn't have intended. When I think Dave (indistinct) because of the sitting, sitting there at home, he seems okay but a little bit off. Got him to the appointment. Halfway through the appointment which they'd asked me to give attendance, his psychologist left the room, psychiatrist, I should say, left the room, came back, and then he stood back away from the desk as opposed to being near us, which I thought was a bit odd.

Our appointment finished at 3pm, 5pm that afternoon, the psychiatrist phoned me. He said your son is psychotic, he is a danger to himself and the public. You need to get him back here. I said to him, I only left it two hours ago. Why didn't you keep him there? He said, 'Because you were with him.' Is aid, 'How am I going to get him back there?' I said, 'I can't.' And that's 7 o'clock on Friday so Trish and I discussed the situation. Going into the weekend, we decided it was pointless because he'd been discharged against our wishes in the first instance.

So we kept track of David every day or so. He seemed to be coming okay and then on Boxing Day, I received a threatening text. So once again we called the ambulance and police to get David back into medical care. Because David didn't want to be there, he was angst against us

which I can understand. He didn't want to see us, so we couldn't visit him. Then on 4 January, we managed to get a visit. We managed to – we were escorted into the main common room of Bungarribee House and then David appeared. He circled us until the psychiatrist came – sorry, the Registrar. So the Registrar met with us and David continued to circle us and bump his chest. And I said to the – it was so hard to register. I said, 'Look at him? He's off his face?' He said, 'I'm recommending that he be discharged tomorrow.' He was not even put back before the Tribunal. I do not know why.

One of the reasons it might have been, because it's 4 January, whether they couldn't get enough staff to do it or not, we don't know. But once again he was discharged against our will. And he almost (indistinct).

At the first tribunal, I stood up. Trish and I were given our opportunity to speak. We both spoke and I clearly stood up and said, 'David needs help. Please send him to compulsory rehab.' So for the second time, you know, we were quite upset because of what had happened; we stopped sort of contacting David. And then on 22 January, the attack happened. So that was only 17 days after his second discharge and I won't go into detail, I don't think. But some of the problems as we see it – and look, I'll preface these by saying some of the staff we've experienced through the forensic or mental health system have been brilliant, they go above and beyond. However, however, some others don't even want to communicate with you. And for the ones who have helped us, we've got some (indistinct) for those people.

It's all the other problems and values that we see in the system, young mentally ill person is not capable of making a rational decision and yet they're treated as a normal adult, which they are, but they're not capable of making any sort of sensible decision. So I feel that some authority should be taken away from them. We, as parents, perfectly responsible parents, even though we were given opportunity to speak, it wasn't really considered what we had to say. And there's a definite imbalance there.

When we were leaving Bungarra House the first time on the last or second last day, I thanked one of the nurses for their assistance and help. And I said, 'I may not see you again' and so I thanked him and he said, 'I'll see you again', I said, 'Well why do you say that?' He said, 'David's not ready to be discharged, he should be held here for at least another fortnight.' So my point here is that psychologists and psychiatrists in the system, they've got a terrible, difficult task of assessing people. So I don't know whether there's enough weight given to the nurses, you know, who are spending up to eight hours a day with the patients. Whereas, you know, I think they should have a greater input in the outcome.

After David was discharged the first time, I received a call about 8.30 one night from the follow up person saying, 'David's not answering his phone calls, we've been to his house, there was no one there, can you contact him and talk to him?' And I said, 'Well, why don't you try and text him, he texts all the time?' I said, 'That's what young people do', and he said, 'Well we're not allowed to text.' And I said, 'Oh', and then he said, 'Well some people fall through the cracks' and I said, 'Well that's not good enough', I said, '(indistinct) '.

But anyway, nothing seemed to happen but my point there is, I think the system needs to embrace technology. Young people today they're texting all the time and apparently it was in the protocol that he couldn't text. I think people in the system who are known to be non-

compliant - because David had previously stopped his medication of his own volition, I think when they're in here the first instance they should be warned that once they're discharged if they fail to comply with the conditions like taking medication, I think it should be automatic re-admission, either by parents or carers who can call up or the treating team. They need that authority to say, 'Okay, you're non-compliant, you're back in the system.' If they were advised that up front, they'd be more inclined to be compliant, obviously not everyone is going to be, but they need to be more strongly encouraged to.

I think it may be a problem of the system is the Mental Health Act. A treating team can only hold a patient against their will for a maximum of 14 days. Now, it can take longer than 14 days to properly diagnose a new patient. That's from the literature I've read on the system, because there can be multiple illnesses coupled with drugs or it can be just be a by-product of illicit drugs. And they've got to be off the drugs for a certain amount of time before a proper diagnosis can be taken. So it's not fair on a treating team that they've only got the authority to be retain 14 days. Whatever the timeframe is, I don't know, but it should be something like at least three months or more before it goes to a tribunal.

I think, there needs to be more facilities in terms of compulsory rehab. We as parents we wanted to do everything possible to prevent what actually happened. We could have financed compulsory rehab but we had no legal way of doing it. It's impossible. The only possibility is if we'd broken the law, arranged kidnapping or something like that. Now, we can't do that. We were powerless, and we're not the only ones, there's lots of parents in this situation. But there is no facilities and we have to rely on psychiatrists, that's why they need to be given more authority, more power than what they have at the moment.

And when they arrived at our place on that night of the incident, the only reason I had him admitted is because I saw an opportunity to help him, we wanted to help. The system had turned us away. So we were left with ourselves to fight the battle, and we did, and it almost cost our lives. It shouldn't be like this.

Even now when David was found not guilty because of mental illness, he remained in gaol, put in corrections for 12 months. That is terrible by anyone's word. There should be a system - like they say he was transferred to other sections but gaol is gaol, there's no ifs or buts. The law should be changed, once a person is found not guilty, they should be out of corrections within seven days, and the government needs to find enough money to finance this. They can find it for the stadiums and what not. The system is opening, is over 168 hours per week. Stadiums are only used about three hours a week if you're lucky.

There's not enough beds in the mental health system and that's causing a backlog in the gaol. They're just held in gaol until they can get a bed. Now, even now, David's recently been approved to go to (indistinct) unit. But there's an approximately a six month wait, so that's more proof there's not enough beds in the system. And unfortunately today there's more mentally ill people than ever before but the funding is not matching the increase of mental health problems.

If the system was more proactive up front as opposed to reactive, we believe that our situation was entirely preventable. You know, we tried but it's too hard just with parents. The system has to support and that's - I've gone over the points. I really appreciate the opportunity and

thank you. Once again, we really appreciate those staff in the system that helped us. Thank you.

PROF KING: Thank you. Just a couple of questions.

MS ABRAMSON: We just want to extend the time to talk to you.

PROF KING: You've raised a large range of really important issues. I'm going to touch on one which is, I suspect, the hardest one from your perspective. Would (indistinct) difficulty or the right to be individual and the rights of the carers to care in trying to balance (indistinct). Now, I wonder if you've got any thoughts about how we can improve the system to make sure that – let me give a simple example. You were mentioning somebody who goes off their medicines so they're non-compliant, for a mental illness and potential actions that should be taken. That would be very different to what we'll do for say, a physical illness, so for someone who was a diabetic and there'd be the child and they're off their medications, they're eating badly, and you know that is going to lead them either in hospital or dying.

But as a society we make the judgment, well that's the individual's choice, so for a physical illness. For a mental illness obviously it's a much, much harder situation to be get that balance right. Have you got any thoughts about how we could change the system, is it a matter of independent advocates being able to be brought in by a parent who can evaluate the situation and who can say, 'Yes, the parents need to have responsibility for certain things here or not.' How do we deal with this because it is, you know, it's a moral dilemma that we're facing in our system and it's one that I haven't got answers to. So it'd really be very interesting hearing your thoughts?

MR ANDERSON: It comes back to my point where once their admitted to the system, I think the treating team needs authority to retain them longer to get proper assessment. And if mental illness is suspected, coupled with strong illicit drugs, they've got to be held in the system. There's just no other way around it because, you know, their system has to be cleared of the illicit drug and then they can determine whether there is underlying mental illness. And when there's a combination of both it's just a terrible situation.

So I know there could be overprotective parents but you've still got to keep these people in the system for proper assessment and there could be – you know, the tribunal could address that after three months. So there's still protection's there for the individual if the parents or carers are estimating the problem. But, you know, Trish has been a nurse and now a clinical nurse consultant all her life so she knows all about caring, and you know - - -

MS ANDERSON: I think there are a lot of services available but I've been to functions and they've said the funding stops after 12 months. So, if you're in this situation, mental health is a long term issue, it's not a 12 month issue. So you speak to the people that work in the NGO's and they say well their funding stops, they're staff start to leave at the end of nine months to look for something else, to go somewhere else.

But with our story, you can only tell it so many times and it's exhausting. You need to move forward. We're now from – from, you know, the courts through the corrections and now in justice health, and we're progressing that way. It's exhausting to keep going back to the story

of why we got there. It's about getting better, it's about moving forward, it's about support and there are lots of people that will support and advocate but there needs to be financial support for these people to know that yes, we have a job.

When you're approaching different services and you're redoing your story, it's just exhausting and you just stop because you're going back to square one, you know, and people want to know if you see a counsellor. Yes, you see a counsellor, the first visit is the story again, and then it's the next one, and then – well that person doesn't suit you, so you're looking for someone else and that's when you stop. The carers stop because you're approaching lots of people but no one can actually help you, and then all of a sudden you find someone that will and there are, you know, marvellous people out there who will connect you with people and will help and that's how I've gotten involved in the carers reference group at one of the hospitals and on the Mental Health Council, because we need to have something that is accessible to everybody, that there is equity in the system. You know, I don't think one story is any worse than anyone else's because everyone's struggling and everyone wants the best outcome for their family.

MS ABRAMSON: Mrs and Mrs Anderson, can I thank you for coming to talk to us this morning because it must've been a very distressing time and getting the real life experience of people really matters to this enquiry. So thank you for doing that.

I wanted to ask you a couple of particular questions. We've been thinking a lot about what Commissioner King just talked about, balancing the rights within family. One of the solutions is an advanced care direction which is correction which is when a person is well enough to make informed decisions actually executing a form which says, 'Well, my parents in these circumstance will be able to make decisions for me.' But given what you've said about your son, do you think that would've been any use to you or would he never have been in a position to give you that authority?

MS ANDERSON: I have been to talk with Carers New South Wales and that was bought up, to look at the power of attorney during power of attorney. But when you have a crisis situation, which we did, it escalated quite quickly, there was no – no time for that, you know. And to get legal people or professional people into – to the services is quite difficult. We were using Legal Aid initially and yes, they're overworked but the Legal Aid representative was hiding behind the door and didn't want to talk to me. You know, as parents, as carers, you know, we're – up until this event we were honest, you know, honest people, I had a speeding ticket, that was it, you know. And then all of a sudden you're thrust into this system that you're not familiar with and it's going on around you, you're involved in it, but you don't actually understand it.

MS ABRAMSON: I think the proposition is that you would do it not in a crisis situation, so just like with elderly parents, you might get a power of attorney administered. So that's the point of the proposals that we're actually thinking, that already there. So you would have that in a crisis situation. I guess my question was yes, within the crisis situation you're not going to be able to – the person is not well enough to give that direction.

The second thing I wanted to ask you and if you don't want to answer it, that's fine, is the mental health care that your son received when in the corrections system. Because the evidence given

to the Commission has been on a number of occasions that's the first time somebody actually got care, imperfect though it is. So what has been your experience?

MS ANDERSON: After time he was transferred to the hospital at the (indistinct), and the people were very caring and administering medication. But with comorbidities I don't – they're not addressed, as such, being a type 1 diabetic, that wasn't taken into account and the weight problem, and as well as the medications. It was, for him personally to be out of the criminal sector and into a hospital facility, per se, was better for him, was less stressful for him, and the people actually spoke to us more. We had more connection with the people in the hospital with the social workers, with the nursing staff there. Whereas (Indistinct) to corrections you're just thrown in ultimately. So, yes it wasn't but it was acknowledged and he was connected with psychiatrists and treating people that were actually addressing his needs.

MS ABRAMSON: Could I ask - - -

MR ANDERSON: But the care in corrections is nowhere near as good as the forensic system. That's why they need to be transferred, because the longer they stay in corrections, the worse they're basically getting. And to go back to your previous question, with that authority?

MS ABRAMSON: Yes.

MR ANDERSON: The problem is that the individual or the person, they think there's nothing wrong and they think everything is perfectly normal even though they're irrational or delusional. So they're not going to give authority, I don't think.

MS ABRAMSON: No. You actually highlighted one of the difficulties. It will work in some circumstances where someone has some insight into the illness (indistinct), and it will work in those circumstances. That's why I was pressing you a little bit because what you say to us is really important and trying to think through what a solution might be so that the family does have an ability to have their say and have their say respected. It's not just about you being able to talk, which you said the Mental Health Tribunal, it's about someone actually giving weight to what you said. As Commissioner King said, we've got to think through what we might be able to do there. Thank you.

PROF KING: Thanks for presenting today. I think one question I have, the delay in transfer from Corrective Services to Forensic Mental Health from your understanding was the lack of the number of beds in the Forensic Mental Health system?"

MR ANDERSON: Yes, without a doubt.

PROF WHITEFORD: Thank you so very much for coming in and sharing your (indistinct).

PROF KING: Next we have Rebecca Davies. Rebecca, if you state your name for the transcript and any organisation you might be representing?

MS BURDICK DAVIES: Certainly. My name is Rebecca Burdick Davies. I'm the director of policy and advocacy and government relations at Suicide Prevention Australia. For the benefit of the Commission and anybody who's not family with our work, we are the national

peak body for suicide prevention in Australia. We represent many of the largest not-for-profits operating in the mental health space as well as the smallest. I have a few opening remarks, if I may?

So first of all, I really appreciated listening to that powerful lived experience testimony that came before me from Mr and Mrs Anderson. I feel that their evidence has really (indistinct) the opportunity that we have here to get the system right. We feel at Suicide Prevention Australia that we've reached a watershed moment in history, (indistinct) we have the productivity commission's enquiry on the way, and we have the Prime Minister committed to reaching a zero suicide rate. We have the appointment of a national suicide prevention advisor, we have a Royal Commission into the Mental Health system in Victoria that can (indistinct) that this is – it's an unmissable opportunity to reform the mental health systems, and so we really appreciate your attention to this issue.

First of all, there was some key things in the draft report that we found particularly welcome. So the emphasis, of course, on whole of government collaboration was something that we were delighted with. I think it's an expression that might not be particularly meaningful for some people in the community but from a policy perspective it's extremely important. We see that the health ministers have agreed to execute an agreement, we hope that they will sign that agreement as soon as possible, a national mental health and suicide prevention agreement, and put it into action.

However, supporting that agreement we need to see some practical mechanisms to make that whole of government collaboration real. Things like, for example, a compulsory assessment of suicide prevention and mental health impacts as part of the cabinet's submission process, we'd like to see that at the Commonwealth level. We know that a couple of the jurisdictions, Queensland, for example, has already put that mechanism into place. We also appreciated the Commission's observations around digital technology and the opportunities that that presents to open up access for patients, particularly in (indistinct) in rural and regional locations.

What we do hope is that the Commission will turn its mind to the full opportunities of digital in the 21st Century. So, digital is not just a mode of delivery, a mode of connecting clinical support services or real life clinical support services with a patient. It's also, you know, a platform in and of itself, so you only need to look at, for example, ReachOut's platform for young people to see the possibilities that digital presents. I think Mr and Mrs Anderson, actually made an observation that their son would have benefited from access to digital means of obtaining support. So I thought that was a really interesting case study to underpin that example.

The emphasis on after care, so speaking from Suicide Prevention Australia's viewpoint, after care is absolutely critical and it's something that we find is particularly patchy across a number of the jurisdictions. Victoria is doing some fantastic work in this space. They have – the full name of the program is the Hospital Outreach Post-suicidal Engagement initiative (HOPE). It's been trialled in some locations in Victoria. We need to see a national scheme of this nature. We all know that or the Commission would be aware that the people at greatest risk of a successful suicide attempt are those who survived a first attempt. We need to follow up with them closely in the first three months at least, after the first attempt has been made.

There are also a couple of things that we felt were not touched on in the recommendations, although they were of course considered in the body of the report. The first is, that we hope the final report itself provides a very clear road map with clear signposting for government to take up. We feel that has been missing from previous enquiries of this nature. The World Health Organisation, of course, has been recommended for years, the three pronged model, one which comes up with a strategy for the population level to address equity and social determines. Community level strategies to improve social inclusion for priority populations and then individual strategies. So we think it would be particularly useful if the final report were organised in that way.

Data, you may have seen some (indistinct) media reaction and public commentary on the report. But we really do hope that there's some strong recommendations around data in the final report. We can only improve the services and the program (indistinct) programs out there in mental health and suicide prevention if we can measure their efficacy. We can't do that with patchy, fragmented information that's out there at the moment, particularly on suicide. We only, for example, have two jurisdictions, Victoria and Queensland with a suicide deaths register. That has to change.

Another thing that we would like you to consider is the whole issue on workforce planning. We've heard today, for example, that some people in the mental health system are very highly skilled, very caring, very well-equipped to deal with the situations that they're presented with and we also know there are significant training gaps. They're also in the informal suicide prevention and mental health workforces. So we have a range of clinical services available. We have a range of health services available. But we also have other touch points in the community for people who suffer from mental ill health and who may be at risk of suicidality or taking their own life. We need to (indistinct) to those people as well.

Coming up with a workforce strategy of that nature, we know would be a task of some years. That's why we would also like to see investment in some practical scalable measures that quickly delivered in the next year or so and they would really address those urgent gaps. From those, for instance, we believe that training for clinicians and emergency department workers, there needs to be a concerted effort to upskill them. For example, we know that only 14 per cent of paramedics have appropriate mental health training. So appropriate training to respond to someone with a mental health crisis.

We also know that a casual conversation can change a life. For people living in rural and remote communities, a lot of those conversations happen with their local pharmacist. In New South Wales, we've seen a small scale of investment of a million dollars invested in a program to deliver first aid in mental health training for pharmacists. We would love to see that initiative rolled out across the country, pharmacists really are regular touch point for people out in the community and often a friendly conversation can turn into an opportunity for something later, for direction to support services.

Finally, we think there's also an opportunity to ensure that all the public money, all the investment that we've seen put into the mental health and suicide prevention systems is delivering a return. And a return for the tax payer and government really means that the services and programs invested in are high quality and that they deliver outcomes. And from a suicide prevention perspective an outcome is a reduction of the suicide rate. We believe the

best way to ensure this happens is by putting in place a national sector led accreditation scheme, similar to that, that we see in other industries. It's something that we will be expanding upon in our written submission, which will be of course made by 23 January but we think that that would be a very important way of really lifting the standards in the sector which is something that we have heard through your hearings, is a problem

PROF KING: Thank you. A number of issues there, my colleague might touch on the (indistinct) scheme but I might leave that, as you said you would be putting in another submission that touches on that. Let me go to workforce initially, one of the issues that's been raised in some of the other hearings is a lot of the community services are provided by the not-for-profit sector and non-government organisations. We've heard already this morning the issues of the (indistinct) contracts and (indistinct). We've also heard, similar to what you said because they're often the touch points for people's mental ill health. That there needs to be more of a workforce strategy, more upskilling of that workforce. Our report goes into some detail about peer workers but not generally into that sort of strategy for the NGO workforce.

I mean I guess I can see some benefits, I can also see some issues. The NGO workforce, in a sense, it's not a high paid profession. It's got low sustainability in the sense that they are surviving on short term contracts and you suggest that they get extended. But putting peer workers to one side, because I think that's an incredibly critical part of it. But for other workers in that sector, what do you actually see as being the relevant upskilling, and is there a risk that by doing that you actually end up with fewer people working in the sector because simply it's (indistinct) hard to get that - - -

MS BURDICK DAVIES: This (indistinct). Okay, so when we talk about upskilling, we're not necessarily calling on government to focus their attentions on people who are already trained as, for example, mental health nurses or psychiatrists. We're talking about people operating the public health system and also outside the public health system who are a touch point for people with suicidal crisis. I don't believe that providing basic mental health training or suicide prevention training, for example, would involve identifying the kinds of words that someone might use, that express that they were in a crisis.

I don't believe that that would necessarily be a deterrent to someone seeking entrance into the workforce. I think there's a broader problem which you've really touched on, which is the fact that there's insecure forms of employment in the whole sector. We need to see funding certainty, we need to see governments committed to, for example, providing three or four year or longer term funding streams, so that people aren't at the mercy of (indistinct) contracts. That's what we see as the biggest issue there. But with the whole area of upskilling people outside that formal suicide prevention workforce, we see that those people (indistinct) benefit. If you're a pharmacist in Bourke, for example and you have someone presenting to you who is obviously expressing some issues with mental illness, that person, that pharmacist would feel far more confident in engaging that conversation if they're provided with the appropriate skills and training.

PROF KING: Thank you.

MS ABRAMSON: Thank you. I wanted to ask you about data. We're very interested, as you would know from our previous work in data. So what sort of data were you thinking of and

how would it be used? And I guess the corollary is with data, always worrying about the rights of the individual, the privacy but also the public benefit that might flow?

MS BURDICK DAVIES: Of course. That's really important to strike a balance on that point. I mean, you would be familiar that there's a couple of strategies on the information management side that you can engage in such as the (indistinct) data of there, the application of data that you might - - -

MS ABRAMSON: Yes.

MS BURDICK DAVIES: - - -(indistinct) private concerns. The sorts of data pieces that we're looking for, number 1 really covering social determinants, so social determinants of health more broadly and suicide in particular. It's such - I think resolving in I think policy makers see that as such a bigger problem. If we have data on what those social determinants mean then we can actually - I think that excuse is taken away, we have to see some effort to resolving them, so, for example, you talked in your recommendations around increasing the availability for empowerment to (indistinct) this social determinant issue. So we need to see additional data on that. That can be by extending the national mental survey so there's an opportunity to expand that into the area of social determinants, particularly for priority corporations. So I think there's been a discussion around Aboriginal and Torres Strait Islander social determinants, explained in that space. And then I think also mentioned the fact of the issue of the suicide death registers in the jurisdictions. I understand that the Commonwealth Government doesn't administer those.

MS ABRAMSON: Yes.

MS BURDICK DAVIES: But it could be an opportunity - there could be an opportunity to tie that to the national agreement. If we don't have a suicide deaths register in every jurisdiction then we have no opportunity to really measure why, who, where suicide deaths are occurring, and we can't really tailor policy making in the way that we need to.

PROF WHITEFORD: So just staying with that point, the suicide death registry, one of the concerns that's been raised with us is the determination that the death was suicide and often that needs the coroner's involvement and that results in delay in recording the death, and the year it occurred, et cetera. Have you got any comments to make about how that could be improved and how you've seen it improving over the years?

MS BURDICK DAVIES: Yes, I think Vitoria has done some really good work in that space, particularly with the timeliness of the way that the coroners are conducting their investigations. I think it's something that we will have to expand on in our final submission. We are in conversation with the New South Wales Government around their suicide deaths register introducing a suicide deaths register here and I think I need to do some more analysis around what the barriers to that might be.

PROF WHITEFORD: Okay. So from what you're saying it varies from state to state about how well they're progressing that.

MS BURDICK DAVIES: That's correct. Yes. And there are only two suicide deaths registers

right now, Victoria and Queensland.

PROF WHITEFORD: The second question, so going back to the issue of training one of the, I guess, concerns and even criticisms that we've heard about mandatorily introducing suicide risk checking in assessments in peer departments or wherever the person might present is the tick box approach where it might be, Yes, here are the questions you asked, and you ask the question, you get an answer and, yes, that's completed. And I guess it seemed to be perhaps ineffective in assessing the suicide risk. Has there been any thought given to any standardisation or examples of where that's worked well or where it's been improved to the point - - -

MS BURDICK DAVIES: Yes.

PROF WHITEFORD: - - -where you believe it's good practice.

MS BURDICK DAVIES: So I believe in Scotland they rolled out - it wasn't a training regime of the scale and scope that we're proposing but they did invest in some training outside that, as I said before, mental health workforce. I understand their suicide rate has increased over the past year, but in the decade prior I think they were one of the only developed nations to see a really significant decline. Yes, I think Scotland is one of the jurisdictions that we'll be looking to and we'll be emphasising case studies from Scotland in our final report as well. Japan is another jurisdiction I think where they've invested in training. I think that's primarily been as part of their whole government approach, so people in the department of welfare and other departments that might touch on or engage with people who have - who are at risk of suicidology, they're being provided with some level of training, so we'll be looking at their results as well, the case study as well.

PROF WHITEFORD: Right. Thanks very much.

MS BURDICK DAVIES: Thank you.

PROF KING: Thank you.

MS BURDICK DAVIES: Thanks very much.

PROF KING: Next Associate Professor John Allan. And if you can state your name for the transcript, organisation you're representing if any, and then any information.

DR ALLAN: Thanks very much. Good morning, my name is John Alexander Allan. I'm the president of the Royal Australian and New Zealand College of Psychiatrists. Thank you very much for inviting me. Can I just start by acknowledging the traditional owners of the land, the Eora people, and pay my respects to the elders past, present and emerging. And also can I just acknowledge people with lived experience of mental illness and particularly their families and carers as well.

So thank you for inviting me to speak. The Royal Australian and New Zealand College of Psychiatrists is the body that represents psychiatrists in this country and New Zealand. There are 6600 members of which 4900 practising psychiatrists and about four-and-a-half thousand

of those are Australian. And there's 1600 registrars in training psychiatry (indistinct) representation of psychiatrist training and I speak for those people. We think there's no better health specialists who are in a position to provide advice. We gave a submission earlier which based on extensive consultation with our members, but I might rehashed that, and really just to say formally that we really welcome this opportunity. We actually agree that this is a once in a lifetime opportunity to make some changes. I'd like to talk about some of those. What particularly concerns us that people are living with mental illness in this country often have very, as you know, very fragmented services. We're particularly concerned that about half the people who have serious mental illness either have no services or inadequate services.

We gave a submission recently to the New Zealand Mental Health inquiry noting that (indistinct) the five per cent. There are five per cent of people in this country who have a serious mental illness, some people who (indistinct) with psychosis and bipolar disorders that includes people with some quite serious personality disorder, anxiety disorders, depression, and other childhood conditions as well. And we're quite concerned that access for those people, the fragmented system and quite a variability of treatment and all the things that you've heard, so we're really quite concerned about that.

We're very encouraged by your recommendation of the multi-sectoral approach. We feel that that's very important and many of the recommendations we would endorse. I think our main issue is with the complexity of the system and how far the reform is going to go. So we would endorse the establishment of regional commissioned authorities. We know that there's significant (indistinct) issues that (indistinct) governments, around the consumer, the care and welfare and is yet to be determined, but also we're concerned about the separation still of Medicare funding and the other funding, so that we're just wondering how an integrated system would look around that and have some suggestions that might help around that, particularly as 50 per cent of our members are actually involved in private practice so there are issues around performing work in public and private practice that we would like to know, and we hope that whatever it is doesn't just give us more of the traditional funding silos.

So we're also quite concerned that the system is (indistinct) crisis and that although we support the introduction of that that it might need to be trialled instead of regional - although metropolitan areas first, because we're just worried about that high level of change, and a good example of that was the moving of funding for PHNs, a very good effort and a lot of hard work by PHNs, but we've had many flowers bloom by the variation and capacity across the country, so those issues about what's centralised and what's local are particularly important for us.

We're also very concerned about the current mental health workforce to be able to meet the demands and you've flagged those points about disparity in distribution and so on. But we think that you've made some recommendations about more psychiatrists, and we'd invite the Commission to help establish a benchmark of a minimum number of psychiatrists required to offer an integrated system as well as looking at benchmarks around beds and community based services, and we know the national (indistinct) framework which is not accessible to all of the players in the is part needs to be accessible. We note that it's - we can talk about that, but it's also professional agnostics, so we need to sort of think about the roles of people in that, but it's a good place to start, but obviously it needs to be made more available and we can talk further about that, and particularly the training that will be required so that we can use that responsibly rather than using it for any kind of malicious purpose.

Also we stress it's just beds it's about community based services. We also note in the report some talk about physical health of people with mental illness and we actually know that people with serious mental illness usually they die 15 or 20 times earlier and that's right throughout the system but of course it's also the effects of diagnostic overshadowing, failure to get treatment for cancer and so on. And also that if you look at the mental health aspect of many, many people with chronic conditions they're actually quite severe, so it's also a challenge because the report recommends the integration of physical and mental health services, whereas it also recommends a separation of funding for those two, so obviously there's a challenge in that as to how we would achieve both of those aims, and (indistinct) to the future.

Also very supportive of the availability to Aboriginal Torres Strait Islander people effective self-management and how we might well do that through those organisations. Particularly we would like to increase the available Aboriginal and Torres Strait Islander psychiatrists who I think have a role to play for us.

And overall we think that the professional involvement of governments in decision making on both sectors, the public and private, needs to be regained. We think that there's a lot that's been lost by not using professionals to enhance the planning as well as the (indistinct) governance, so we'd like to see that. And obviously we're making a more detailed response to a number of your questions and recommendations further, but I'm happy to take questions on any of that.

PROF KING: Thank you, Professor. Let me start off, you said your organisation has some suggestions for the issue of the separate funding problems, for Medicare funding, and we've got other funding, grant based funding, block funding, activity based funding, funding under various approaches, and you had some suggestions for avoiding or perhaps bringing those together. Can I get your suggestions?

DR ALLAN: Sure. So there are many and varied, all right. So some of those are around increasing the number of psychiatrists and dealing with (indistinct) distribution and I'll come back to that if you like, and (indistinct).

We also note that the Medicare funding and, particularly better access, but also the direct access for doctors is quite poorly distributed. We wondered if the RCOs might not be able to think about that distribution and we suggested that there be a weighting of population in terms of the way the funding is used. Then they be - (indistinct words) are very good more in the sense that it gives a person certainty about seeing a doctor and that relationship between the doctor and the patient but also aspects about contracting that might be useful as there (indistinct).

There might be issues around incentives that we talked about being able to use the psychiatrist, not just on a one-to-one situation but to be able to (indistinct) across public and private. The other offers supervision to other providers for psychologists and other allied health professionals, to team with the mental health nurses to actually provide someone with serious mental illness (indistinct) to public or private so being able to team those people and to provide private service for a person with a serious problem which could be either NDIS funding, their medical services and their personal (indistinct) health might be a really good model.

In terms of effective in-base funding I think that's the next question, because obviously with

growth in mental health services, services rely on the on the (indistinct) to actually help with the increased demand whereas I think you've made the point that by funding always that way there's the incentive to continue to do it best. Our experience would be that in the public sector the pressure on the acute beds are so high that I don't think anybody thinks just about (indistinct) again with funding, I think they just think about demand, and so the first incentive is about the funding of the things in the community and the alternative to those hospital admissions, so obviously we note that we've got 50 per cent of the (indistinct) beds that we need, so there's a whole range of things that need to change.

PROF WHITEFORD: Thanks Dr Allan. So just coming back to the issue of training, one of the things we've heard - actually I'm sure the college is familiar with this, that a lot of the training is done in the public hospitals, and there are therefore constraints around the skill base that registrars may get trained in. Is the college able to suggest ways which we could broaden the type of training that psychiatric trainees are exposed to and then - - -

DR ALLAN: Sure. So around 170 of those training places were in the STP or IRTP the specialist training pathway.

PROF WHITEFORD: Can you just - so - - -

DR ALLAN: So that's a federal funded program that provides money for registrar to train in places they would not normally train, so out of the public hospital high volume system. So those can either be in rural places, for example in rural/regional Australia, particularly in remote and indigenous communities. They've also been used in lesser used specialties so in areas like a brain injury, neuro-psychiatry, perinatal mental health and also used in private hospitals for training so there's been some settings in the private as well.

And recently we've been able to focus with those particularly on rural training, rural and remote training, however we would - and that's been great and really, really appreciate that. But we also recognise that there are other areas in which that can be used, so for example in private practice. It tended to be used in private hospitals under supervision, but they could be used in large private practices as well. There's some issues around item numbers for registrars to provide and item numbers for supervision that could be changed around that.

There's also issues around payment for psychiatrists for the supervision that's required. A recent example that's really useful is that we've redirected with in conjunction with Department of Veteran's Affairs five of those places to be particularly in military oriented places so we're actually opening up psychiatry training places in military bases and in military hospitals that hadn't been there before to address the shortage in needs of psychiatrists for veterans and military psychiatry. So with a targeted approach like that we can actually open up a whole different field.

The problems with those have been that sometimes the funding hasn't been sufficient and then the costs of - the private institution that have been providing that so that needs to be reviewed. And there's been (indistinct) but they've been very successful. They need to look at that. So they need to do that. And the other one is that, as you know, with the public hospitals the pressure on work, the pressure on workload is not what it was when people like I trained in 20 - 30 - 40 whatever years ago and I think (indistinct) that supervisors don't do that same amount

of time devoted to teaching.

How people deal with that experience is not exclusive as it used to be, so there needs to be some different ways of funding for supervision and different ways of funding the training experience that would be more suitable to get that more balanced for psychiatrists. For example different if a psychiatrist need to be trained in psycho-therapy there is a time in the public - in a very busy public system and they're not (indistinct) with the training in psycho-therapy to do that, but if you think about the way that we need to treat them with anxiety and depression and other serious disorders that psycho-therapy training is the backbone of a lot of that psychiatric work, so we need to have new models to provide that as well and that might just imply higher supervision using supervisors from outside similar to the indigenous people we, you know, therefore would use cultural guides to provide that supervision in the services and so on, so there needs to be that range of different experiences and we've got to prepare people for this world, not for the previous world, they need to know.

PROF WHITEFORD: So could we just follow - one question on that, so has the college got any views about the different ways we could fund that training so that we could get the balance right but also given what you've said about the pressure on psychiatrists who work in the public system and their lack of availability to do the training that they had done maybe in the past, have you got suggestions about what we could look at to commend - - -

DR ALLAN: So, look, I think that the expansion of the STP and IRTV system is really very important because that's (indistinct) so you could increase that now and deal with that. The number of training places for psychiatrists have been limited by the fact that the funding to the public health systems has been limited so it really (indistinct) in other places. So that general increase in funding would increase the number of places, and particularly if there is a shortage like child adolescent psychiatry is a bottleneck in training and yet we need more, we need more perinatal infant psychiatrists because there's a whole push that you have suggested around early years requires those psychiatrists to deal with the training aspects but also with the treatment at the severe end. So there's that general increase in funding that we might need to have, those STP places are cheap for what you get, 100,000 - 130,000 per place per year is quite - you get good product. Some Medicare revisions to allow item numbers for those registrars working in private practice, because they're actually seeing the patients and working under supervision through that work, so it's a good investment to allow (indistinct) private health insurance and so on as well, so that you get a better scope.

PROF WHITEFORD: Does the college allow online supervision of registrars?

DR ALLAN: So it does allow online - well, video conferencing and online supervision (indistinct) rural and remote places, and I've done that kind of work for registrars in that space. We do, however, recommend - we do actually require that some of that is face-to-face, and so that's a combination of the person flying to those places as well as being online and telephone and email correspondence. So we do that. I think funding more of that so there's opportunities to tell the psychiatrists about (indistinct) make recommendations about the item numbers.

We would have some concerns that (indistinct) suggesting. You're going with the - what the Medicare Review suggested, which is why we have one particular item number in favour of (indistinct) that were the sum of that extra funding for setup and the extra work that's required

to (indistinct) and we'll write more about that in our submission. But telepsychiatry is another good way of allowing for that supervision, but there's also face-to-face.

PROF WHITEFORD: So just finishing up on training, so the training provided in the public hospitals by the consultant, I guess that time traditionally has been paid for by the state government, and what you're suggesting is that if there was an item number that could be involved in training in the fee-for-service MBS paid system, that would shift some of that training cost to the Commonwealth government?

DR ALLAN: It could shift, but I think that you have to acknowledge that the payments incurred by the psychiatrists is not just of their work time. It's outside work time, it's weekends, it's lots of other voluntary work. So we really run a training system based entirely on voluntary labour, and even the private system generally (indistinct) voluntarily. So, we've just reached a point of professionalism and volume where there's a need to have stronger supports.

And it's also the structure around training, so that just organising that requires considerable secretarial and administrative support. So we have the state governments support training through directors of training, and they've been reasonable generous. But there hasn't actually been an increase in some of that in some states for many, many, years. (Indistinct) has been some additions, but it's often been quite a pressure. And so that means that the whole thing that's required to mentor and bring those people through is - is quite stretched.

There's also some issues around whether we should need to train psychiatrists for everything, or whether we need to work with our other (indistinct) colleagues and trainers. So we've been talking to the (indistinct) medicine, to the Australian College of Emergency Medicine about certificates and diplomas that we might share, that would - that intersect in that kind of work and they can be used for training in both colleges for GPs, for that matter.

PROF WHITEFORD: How much does the registrars themselves contribute to the cost of their training in psychiatry?

DR ALLAN: Well, they give of their time, they give of their study, they give of their work. They pay fees that provide some recompense for some of the courses that they have. That varies across the states, so there's a formal education process which is like an afternoon a week of learning and lectures and so on, and they pay varying fees from one or two thousand to 10,000, \$12,000 a year on that, and they pay a training fee to the college of around \$1,000. They pay to sit their exams. Often that can be recompensed through their work, but they pay (indistinct) as well.

PROF WHITEFORD: Last question, sorry, is about the commissioning authority. So you gave some comments that you have views on that.

DR ALLAN: Yes.

PROF WHITEFORD: Clearly, that's a major recommendation, that the draft report's been made to deal with some of the concern, in fact, a lot of the concern we've heard about the fragmentation in the community mental health service sector, more broadly defined. It's an area which I think, as you've suggested - the college suggested is challenging. Have you got

any further comments you'd like to make about how that could work to overcome the silos, which is a criticism of the way the fragmented system exists in the community.

DR ALLAN: So, I think this has been a sore on the side forever, since the first national mental health plan. The last plan went some way towards joint planning, joint commissioning, and eventually joint funding. So we're now three years down from that plan, and although we've got some joint planning, we have limited joint commissioning and we have no real joint funding. So the question is, yes, that's a great ambition, but when would that ever be achieved? I think that's the issue.

So surely this joint commission authority could achieve that within our lifetime, rather than some other (indistinct). So I think that's the major reason to support it, because everybody is frustrated by the two tiers of government, and if you ask 90 per cent of practicing (indistinct) the split is just hard to navigate, just in every turn of - turn of the wheel. The different funding models, the different commissions, the different rules.

So just from that point of view, we think that that's necessary. And then it comes down to how far do you go with that. If you're really going to go with it, you need to go with it all the way. But we also have systems that work reasonably well in terms of private practice and (indistinct) service. People get to see the doctor they want, but there are delays. You've talked about how do we deal with those delays as well. We've consolidated within the private practice about those delays.

But we think there is just that opportunity for the different models. Workplaces are underserved. You've talked about being able to use different kinds of contracts and different arrangements, and different working together teams, those commissioning opportunities might fill some voids. We're just excited by the thought that it could be (indistinct), and I think that's really the truth

And we'd like to see a bit more detail, because what does worry me is that this is not just about the funding. The big issue is about clinical governance. So who actually has responsibility for the patients? If something goes wrong, who is actually responsible for that care? Working in the public health system, we know that there's a clinical governance system which will eventually look at problems, disasters where people die, and what should be done about that. That's not so clear in that blended system.

And so, we are very (indistinct) we want to make some strong comments about how that is likely achieved, if you're very concerned about quality care and patient safety. However, we also think that if you employ the best people with the best skills to do that, then surely we can set up a good system of quality and safety.

PROF WHITEFORD: Thank you.

DR ALLAN: Thank you.

PROF KING: Next, we have Dr Angelo Virgona. Dr Virgona, if you could state your name, what unit you're representing, and any opening comments that you'd like to make.

DR VIRGONA: Thank you. I'm Angelo John Virgona. I'm the chairman of the NSW branch of the Royal Australian and New Zealand College of Psychiatrists, and I'm really grateful for the opportunity to represent the 1,200 psychiatrists and 400 registrars in NSW this morning. Unfortunately, I'm following on from John and - which means that, you know, I haven't had a chance to redraft my presentation. But I'll read from it and you'll get a sense that we're all sort of speaking from the same page, really.

We commend the Commission in NSW on the comprehensive body of work that you have provided to us, identifying the major weaknesses, inconsistencies, and fragmentations that characterise mental health service delivery in this country. It's identified the impacts of a poorly functioning, dysfunctional mental health sector on society as a whole, and we support the contention that this isn't a health only issue. We agree with what's raised by the Victorian branch in their - in the hearings and their submission last week. I saw those, and obviously, with John's presentation this morning.

Really, there's this sort of consistent theme that we put in our original College submission about not enough of anything. There's really not enough of anything in the sector, and that has to be addressed. But it's not going to be able to be addressed without fundamental redesign of the system. We were quite excited when we read that you supported the rebuild option for the structure and function of mental services in the country.

The system cannot be renovated. We've had national mental health plans that John noted, commissions, recommendations from various state parliamentary and other enquiries over decades, and these have generally been futile reform exercises. We don't blame those organisations. Their frames of reference have been narrow. They usually end up asking for more money to fix this or that bit of the sector, which usually falls on deaf ears, or gets funded in time limited ways, or it's another poorly funded layer to the sector, confusing it further.

And within the mental health sector, we are really as functional a family of services with multiple players. We all mean well, but we take offensive postures, protecting our own turf with little appreciation for the role of the other players. As well as between major bodies, it occurs within our organisations.

As a fragmented sector thing we've had no success in achieving meaningful reform and we're desperate for a coalition of the major players. There is now the site for change, as you've obviously realised during the course of your consultations.

I represented the college at a national meeting of all the PHN's in May this year. Every major mental health organisation in the country was there, as well as the VHM's of course. In the afternoon, I chaired a session and it was on the implications of the productivity commission inquiry. It was an extraordinary meeting. It was the best attended of all the sessions there because people sensed that this inquiry was our best chance of change for a generation as everybody keeps saying.

We said it in our college submissions to you and he's been saying it for a long time and I am saying it today. I mean, and you said it in your report. The passion and commitment of all the players in that room there, was obvious. All agreed the system was broken. We needed a

blueprint for the future and that there had to be coalition of voices speaking with a single voice that we were going to influence government.

I was at a recent meeting in August of all the state and territory branches of the college and it was agreed that the rebuild option was best among that group. There was also an agreement I think that – for anyone but the Commonwealth to run it in terms of the approach to governance, given their track record in operational management of service delivery.

We also raised the suggestion of states and territories establishing and operating the Regional Commissioning Authorities. But as you pointed out also in your report, they can be wasteful and inefficient with, you know, I think one of the stats mentioned was a 20 per cent of the community staff members times in direct patient context and they have ridiculous demands for providing data and activity reporting.

And for those of us who have been around a while, the history of state-funded mental health care features pilfering and neglect of service development times, attempts at quarantining medical budgets and (indistinct). So that's just a word of caution on that front.

The college branches, before pooling funds, and the notion of the Regional Commissioning Authorities - but there seem to be a failing to consider another serious claim in the sector which was the private sector or the private hospital sector as well. I mean, they are a major player in the mental health service delivery in the country and they have significant operational experience. Full stop. I mean, I don't know if we will talk about this further, but the idea of triumvirates if you like of people of groups that tender or running Regional Commissioning Authorities should be something is considered providing private, public and community management organisation representation. Like John said, you don't want to commission some commission or model without it being tested and then vis-à-vis an identification of options and then trialling options in various sites being metro, regional and rural.

You've also mentioned there John, the issue of maldistribution of MBS rebates. You said in your report, the size of each RCA's funding should be linked to the body of MBS rebates for Allied Mental Health care in their region. But rather than that happening, I think that MBS rebates for the country should be totalled and distributed according to population.

In other branches of medicine, doctors go where the funding is. If a young surgeon wants to work as one, he won't get enlisted to an inner urban hospital when he gets his letters. He'll have to travel to an outer-metro area where the work is available. So it should be for MBS rebates in psychology and psychiatry.

I was going to talk about place and journey and how the development of Regional Commissioning Authorities would enable simpler points of entry or simpler points of entry into sort of into mental health services delivery. The fragmentation of the system gives the impression of good mental health care as a complicated exercise. It isn't necessarily. It requires the right resourcing and the right paths for the patient journey if we are to avoid the step-gap model which characterises the current system.

The pointy end is at entry. The primary care centre has a few problems as you noted in your report. It's not funded to provide comprehensive mental health assessments and the percentage

of GP's if you're confident about doing same is not high. Of course if there are proportionate GP's who can perform sophisticated psychiatric assessment and are comfortable with managing mild to moderate, sometimes in a psychiatric facility – they're in the minority.

Most others are comfortable with assessing mild forms of disorder and comfortable prescribing anti-depressants. Now, taking further steps along treatment algorithms, I agree with you on most of them. We expect too much. Also, many GP settings particularly on the outer-metro areas where I've relied on my Turbo Medical Seven model, and the relationships with the one GP are infrequent in these settings and time is limited.

As you noted, many people have conditions too complex to be treated by a GP. Excuse me, a minute, I just got a fly in my throat. No, no, it was a real one.

Pouring more money into GP education and training has been done to death over the years. Anecdotally, I and my peers have been doing GP education sessions for 30 years. The usual suspects turn up, those with interest and skills in management of psychiatric disorder and they are in the minority of general practitioners. Your suggested solutions to fix the MBS so that they are remunerated appropriately to devote time to complex presentations is reasonable. But there are question marks as to whether that will lead to change.

Access. The first point on the journey for a patient is access. It must be easy and equitable. That can hardly happen with clear unimposing entry points. There are few in number to keep the processes simple. How could it happen? Simple entry points for child/ youth/ adult and aged care services within regions would make sense. You need sophisticated triage and assessment services that should be available across these regions comprising especially trained psychiatric, psychological mental health immersive and other Allied Health staff. You receive the moderate severe referrals, conduct a timely assessment and then refer to an appropriate service within their area.

Their services would have KPI's around the time taken to first assessment. This would be as I said, sophisticated, comprehensive, lead to coherent clinical management, a plan to proposed interventions based on evidence, and then pathways to care.

Retraining and better access is critical and we agree that mental health plans have evolved little. One problem is that GP's aren't often the best equipped to determine the type or duration of therapy that a consumer needs. Distressed consumers need comprehensive assessment to determine their clinical need. To look at a particularly under-serviced and expensive group, are those with trauma attachment to borderline conditions. They need a comprehensive and sophisticated assessment to drive a treatment plan.

So it wasn't that no one presented with symptoms of depression or anxiety, get a GP mental health plan, see a psychologist who may have little or no experience in the treatment of these complex disorders, deliver then a therapy which is not usually evidence-based, often useless and sometimes dangerous, resulting in more distress for the consumer - most psychologists are trying to be equipped in providing CBT for anxiety depressive disorders but not much else.

Many or most clinical psychologists and some registered psychologists had training in additional evidence-based therapies from more severe anxiety-depressive and personality

disorders. And there are NHMRC guidelines now that clearly describe the evidence in this field.

Certainly qualified therapists need to be identified within networks and they are the people who would receive such referrals from a triage and assessment service. I've got a few other points about the community managed sector. This came up in a recent meeting of the Clinical Advisory Council of New South Wales Health and that generally across the state in public sector services people are finding it difficult in dealing with these – with the range and number of services that are available. Of course, there have been reports of inefficiency and waste with the NDIS rollout and there's consistency among the advisory council that there should be a rationalisation of the community managed organisation sector.

Organisations need a critical mass to support an organisation – organisational structure that can set and train appropriate clinical and corporate government's arrangements and can ensure up skilling and maintenance standards with their staff.

I'll leave it at there at this point in time.

PROF KING: Thank you very much. Okay. I'll start off – and lots of points there. Let me start off though, somebody mentioned at the end which is the difference between psychologists and other therapists in this area and we've heard from various groups, psychologists, counsellors and so on about the issues of what there should be funded (indistinct) potentially via NDIS.

You made a distinction between clinical and other psychologists at least in terms of training. We've also heard from counsellors who are a different group again.

What is your view on which, if any, of those clinicians are relevant at what stage or treatment, clinical treatment for a person with mental health issues. Do we need more transparency over the different training? So for example my understanding is psychologists don't have formal schools of practice. Is that needed? Do counsellors have a role in moderate or severe treatment or treatment of people who are moderate or severe should be able to be different?

Those general views and I'm deliberately asking you as someone who isn't one of those practitioners, but you raised it in your statement.

DR VIRGONA: To answer the last question first, I mean, in terms of counsellors, they can get their qualifications from a range of places, including online as I understand it. I wouldn't have thought that they would have the school-based necessary from such a programs to be able to look after people with moderate to severe psychiatric disorder.

To give you an idea, it's hard to get a sense of what it's like out there and at some years ago in the area that I work in in south-west Sydney, I did a survey of everybody I thought who may be working with people with a borderline or complex, stronger, traumatic stress disorder population. So I sent out a survey identifying more of the psychologists through the APS website who were registered with ATAPS.

I set it out to the community health centres in the public sector. Mental health services and all the counselling services that were run in the area.

Now, I received 38 responses – and that's from about a half a million population and I got 38 responses. They're only about that many people registered for ATAPS in the area. And we found that of that group, these were people who were interested in providing services to people who had borderline and complex strong disorders. They all had some sort of post-graduate extra training in delivery of evidence-based treatments to these people. And they were only seen, I think, as a type, in total about 160 people.

Now, what – in the area. And we thought that there'd be a population of around 5000 people in the area given the expectations at the (indistinct). So this is an incredibly underserved group. And a group that has significant morbidity and mortality and creates a lot of need in the public sector and mental health services, both in the emergency department and the in-patient sector.

So that was an exercise to try to get a picture of what it was like out there and I think what it showed us, is that there are people who were trained and then there are people who are actually – and the idea behind this was to approach the primary health network because they had money for complex and severe psychiatric disorder provision and so I said to them, well, what about this group? I mean, they have complex and severe psychiatric disorder, would you consider funding this to some degree.

And they considered it, they didn't do it ultimately. They considered it and so it was to try and get a little interest in the area around us and whether people would be prepared to come together and be a part with a – they would have to agree to conduct and edit it's face treatment for the disorder, according to the NHMRC guidelines and be part of a peer review process within the group and supervision. And everybody is having to do that.

I think programs like that are possible within a regional commissioning network – regional commissioning authority framework that you can develop networks and conditions, you have identified skills, who are registered within your organisation the same and who can receive referrals for patients in that group.

PROF KING: So a question about access. So any thoughts or comments about afterhours access? We've got a lot of people are saying to us that after hours, it's the sometimes the ED department and not much else. Is there examples of areas where we've done better or we can make some recommendations around proving, especially out of hours access?

DR VIRGONA: Yes, I think there's a lot of scope for innovation around this where the college is working with New South Wales Health at the moment on a workforce strategy, it's like our workforce strategy. I am trying to get New South Wales Health to agree to funding VMO's, psychiatrists work, after hours. The peak period for presentations for people with mental health problems to the emergency departments are between 4 and 11 pm. Yes, that's when our staff have all gone home. Our junior staff, our registrars. And the CMC's you might be working in ED.

I'm hopeful that they're going to pilot this at least and see how we go. So in terms of the public sector, there's no reason why that – why such a model should not work ultimately. We've also tried to get them to look at the staff specialists in order to see if we can marry up our award more with the emergency physicians award - emergency department physicians award. Because really, we are an emergency – we are like emergency physicians nowadays. We've got (indistinct) who are just doing emergency department of work. It is not the ideal place to have people present where you have – that we're stuck with it, we can't see a solution to this in the near future, so we have to adapt to the situation and start to engage in workforce design that meets that demand.

So working in the public sector, yes. In terms of the private sector, there's no reason why Regional Commissioning Authority, could find an extended hours triage and assessment service. You know, running their own mental health telephone access line, linked to treat – and a team who perform comprehensive psychiatric assessment and development and management plans. This is part of the problem really, is that people go for years and years and years, before they get to a point where they're getting a comprehensive assessment so that the actual nature of their problem is identified and so they've often been floundering for years before they get the treatment that they should have gotten in the first place.

If you want to do something with early intervention, then you've got to develop the pointy ends of the business properly with the right people in.

PROF KING: Thank you.

MS ABRAMSON: Could I ask you one question about the Regional Commissioning Authorities? One of the reasons behind it was to use some stability continuity over time, so one of the issues that we'll be interested in when he talked about the triumvirate which was the NGO's that – and the government. How would you ensure that continuity in those circumstances?

DR VIRGONA: Well, I think it's a fantastic question and I think continuity of care is what is really missing from the public sector services at the moment. We used to do it about 20 years ago, I would see my inpatients in the morning and my outpatients in the afternoon at the community health centre. I'll look after them both sides and they stayed with me and it went very well. I think another point on a similar theme is that in – I think there's the lack of a consumer and carer activism in the private sector is because people are getting continuity of care in the private sectors.

So people aren't jumping up and down and screaming about the care they met in the private sector because they get their doctor and they get to see their doctor or their psychologist over a long period of time who knows them and can efficiently deal with the problems that come to hand.

So how would you manage continuity of care? Well, I think within a Regional Commissioning Authority, you would just have a network of clinicians that would be fronted by that authority to deliver services. But delivering packages of care that use - that are determined at the outset. Whatever the treatment plan is at the beginning, somebody gets a package of care. If it's

someone with a personality disorder, they want to get 40 sessions a year with a clinical psychologist who's trained up in that area.

And it may be that at the end of that period of time, it's decided they need an extension to that period of care. They would be allocated a psychiatrist if they were requiring psychotropic medications, who would be the person who would continue to provide the care to that person.

Again, they could be funded as John was mentioning, you could contract people to work for you on a sessional basis in that model or you could pay them a fee and service kind of arrangement. I mean, these are the things that I think, that need to be thought about in a bit more detail and then potentially trialled.

MS ABRAMSON: We'd really welcome your thoughts in a written submission - - -

DR VIRGONA: Yes.

MS ABRAMSON: - - - on some of those things because we really are looking at some of the details of implementation.

DR VIRGONA: Yes.

MS ABRAMSON: Thank you.

PROF KING: Just one last one from me. Again, on the regional commissioning authority funding, you said very strongly that the RCA funding pool should not be linked to the current volume of MBS rebates. You suggest that I think a per head, per unit of population approach, but I wanted to clarify that because the alternative that we see from that the GST distribution in this country is where it's done on the basis of a more means based approach, for want of a better word.

DR VIRGONA: Yes.

PROF KING: So you think per head of population or something else?

DR VIRGONA: I think you'd have to consider particular needs of particular population, so if you've got high need population such as CALD or ATSI populations that are concentrated in particular areas then there would be a loading that would be applied to those areas, yes, but, you know, generally speaking there'd be a much more equitable distribution of the existing moneys.

PROF KING: One of the things that's done for the GST distribution is of course saying, well, for example, that you're largely a rural and regional state, as some of our states are, then it's more difficult to implement services, it's more expensive, so more money is needed. Is that something that you'd support?

DR VIRGONA: Yes.

PROF KING: Thank you.

DR VIRGONA: Thanks.

PROF KING: Let's take a break for morning tea until five to 11.

SHORT ADJOURNMENT

RESUMED

PROF KING: Perhaps if we can start again. So is it Marie?

MS BUTLER-COLE: Yes, hello.

PROF KING: Marie, would you be able to state your full name, any organisation you represent, if you're representing an organisation, and any opening comments that you'd like to make.

MS BUTLER-COLE: Yes. So my name is Marie Butler-Cole and I'm here today because I'm a carer for a mental health patient with severe and complex mental health issues who has been most recently cared for in the public health sector.

PROF KING: And any opening comments you'd like to make on your experience or - - -

MS BUTLER-COLE: No, it's okay.

PROF KING: That's okay. I think in your notes that you sent through for us you mentioned human rights abuses in the mental health system.

MS BUTLER-COLE: Yes.

PROF KING: Would you be able to expand a bit on what you mean by that and where you've seen examples. We're very keen - it's incredibly valuable to us to have your experience, to understand the (indistinct words).

MS BUTLER-COLE: Okay. I have been caring for my friend over the last couple of months who went in as an involuntary patient into a major public hospital here in Sydney. I feel that their care has been substandard for the duration of that stay. I do understand from reading the report that there is a need to reorient care to the patient, but the report does not mention that there is a need to respect the patient, to not be prejudicial towards their care because of their background, and I feel that there's been a great lack of empathy and consideration towards them over that period of time. Now, over the course of the six weeks that my friend was in treatment, I noticed that there was repeated failure to enable my friend to give informed consent for (indistinct) of medication, proposed tests to be conducted, speaking to external parties in order to gather information about their background.

Their treating team was also regularly telling my friend not to speak to me and constantly asking them if I'm a trustworthy person. Staff were speaking to my friend with disrespect. On one occasion telling my friend that they were whining when they were asking for supervised or unsupervised leave. There was an apology issued over this, however I believe the damage was done on that occasion. In addition to that there was an initial refusal to provide a carer nomination form and there was resistance from the treating team to speak to me, despite myself eventually being provided with that carer nomination form and myself being put onto that form with the consent of my friend.

The social worker at the hospital consistently refused to perform their duties that was expected of them, for example, my friend wants to apply for Newstart Allowance and on two occasions they had the form printed out for them and they were left alone with the form, with the full knowledge that they would not be able to complete the form by themselves. That's just one example of the many failings of the social worker, and it provided a great deal of frustration for me because I had to take over the duties that the social worker should have done and that came at financial cost to me as well because I was on contract with an organisation and I got paid by the hour. I do not get paid for the hours that I was not at work. So in that case financial pressure on me as well, however I realise that the needs of my friend were greater than being at work because without those things being done and such as speaking to banks or to other lending providers or filling out forms for - to be able to speak to the general practitioner, things like that.

I needed to have a (indistinct) when my friend was discharged and I understood those things were (indistinct) by the social workers (indistinct) not doing those things. A registrar told the Mental Health Review Tribunal that the treating team did not want me to be part of the hearing, and that they were of the view that I am over involved in my friend's affairs and that my friend does not agree with me, that I'm not an appropriate person to associate with, that I'm complicating their care and that I'm going to be removed from the list of their nominated carers, which did eventually happen but it didn't really make much of a difference (indistinct words).

Because of these things, I informed the treating team that I applied for guardianship for my friend through (indistinct) and around 9.30 in the morning, because I submitted the forms the evening before, they woke my friend in their bed to tell them that they were going to oppose the application and that if I'm their guardian that apparently I can do whatever I like with them, which is not true.

Which is really, really hard for - not just towards me but that is so hurtful towards somebody who's vulnerable and has limited access to friends and family because they're not from Australia. And then the final Mental Health Review Tribunal, that was conducted shortly before my friend's release into police custody, was a disgrace. It started late and I understand that was due to technical difficulties and, you know, that's okay things do happen, however there were two versions of the paperwork and there were differences that the tribunal members nor the registrar were aware of until I pointed them out, and then it was closed hurriedly as they were running behind. This is somebody's life that they're playing with, and I (indistinct) find that any of these things that make this acceptable at all.

It falls far short of the professional behaviour that is expected for mental health professionals. There don't seem to be any (indistinct) or remedies to modifying this behaviour that my friend

has experienced to ensure that this will not happen to them nor to anybody else ever again. I will say that if mental health professionals behaved in the ways that I've outlined above, that they've got no place in this industry and that they should find something else to do with their lives if they don't display empathy and compassion.

PROF KING: Thank you. Can I ask what would be the effective approach, would be formal legal protections for mental health patients? Would it be some sort of statement of a mental health patient consumer rights. Have you got any thoughts about exactly - I understand your experience, how do we now move forward? How do we make sure that other people don't have to go through what your friend has gone through?

MS BUTLER-COLE: Well over this time period, I've noticed that mental health patients have significantly fewer rights in respect of civil law, criminal law and family law. I'll just find the section where I've written about that.

PROF KING: Please.

MS ABRAMSON: Ms Butler-Cole, perhaps if I can assist you, we do have a part of our report where we were quite aware of the fact that people with mental illness had more disputes, you know, landlord-type disputes, fines, those type of issues. So we were aware of that and then the question for us was Legal Aid, if it funds, generally funds the criminal cases, so the question was what support could be given to those people? So is that the type of issue that you're referring to or something different?

MS BUTLER-COLE: No, I'm referring to the fundamental rights that mental health patients have under current legislation. So for example in the areas of civil law, it is extremely difficult for mental health patients to sue medical practitioners for medical negligence due to the requirements that I believe there's three mental health practitioners that - I can't remember exactly what it was - that need to be in agreement that the treatments which the patient received was incorrect, and I believe that requirement does need to be removed because in this country mental health practitioners are reluctant to speak out against one another for fear of retribution.

MS ABRAMSON: Firstly, can I thank you for - I understand you've made a submission to us as well, another written submission, so thank you for that and thank you for coming to talk to us today. Can I follow up on what my colleague was asking you about the rights of people under the Mental Health Act, I should add that the Mental Health Acts are a bit different around Australia, so if we can have a look at the NSW Act, which I'm sure is what you're referring to. We've given quite a bit of thought to advocacy support for people performing across tribunals, because there's good evidence that if they have access to representation, the likelihood of compulsory treatment is actually much lower.

In the circumstances that you've described to us, where you were told that even though you had the guardianship, or you had the ability to assist your friend, that was not going to be respected. Do you think if you had access to an independent advocate, that would have assisted you?

MS BUTLER-COLE: I'm not sure. I'm not sure. I've had to do all of this on my own with the assistance of some advice from somebody who knows Sydney and more about the supports and services that we currently do have in place. If perhaps the advocate had legal (indistinct)

to be listened to, then that would've have been immensely helpful. But as I was not - as I'm not a guardian for my friend as of yet, I have found that my ability to assist has been greatly constrained.

MS ABRAMSON: And can I ask you, what type of information were you told as to why your guardianship would not be respected?

MS BUTLER-COLE: Well, for the length of time that I've known my friend, like, I mean, how long is a piece of string. Like, there's no limits on compassion.

MS ABRAMSON: Because we are, as I said, we will have bit more of a look at this issue, because the rights - we were talking to one of the (indistinct) before. It's really difficult balancing carer rights, guardianship rights, and the consumer themselves. So in your case, was your friend well enough to say that I want Marie to be my guardian, or my person to speak for me?

MS BUTLER-COLE: Yes, so (indistinct) sent to their treating team and (indistinct) on a number of occasions, and the (indistinct).

MS ABRAMSON: I will have a very good look at your written submission and we may follow that up too. Thank you.

PROF KING: Thank you so very much for coming in.

MS BUTLER-COLE: Great. Thanks very much.

PROF KING: Next we have Nick Kirwan and Cathy Duloy. If you are able to state your names for the transcript, and the organisations you represent, if any, and then any opening comments you'd like to make.

MS DULOY: I'm Cathy Duloy from MetLife (indistinct).

MR KIRWAN: And I'm Nick Kirwan from the Financial Services Council that represents the life insurance industry. So, I wanted to give some background and context to put on the record the nature of the interest that the life insurance industry has in mental health conditions. And recently, in partnership with KPMG, the Financial Services Council has been capturing some very detailed and up-to-date information about the causes of life insurance claims. It does tell, I think, a very interesting story.

And because of the prevalence of the group life insurance in super, we would expect this data to be representative of the Australian population, as a whole. And it's worth saying that last year, 2018, life insurance companies paid out in mental health claims \$707m, just for mental health claims for income protection (indistinct) policies. And mental illness is the second most common cause of claim overall for life insurance policies. It's the most common actually, for total permanent disability, TPD, and it's the third most common cause for income protection claims.

And we have seen - we're seeing that the incidence of mental health claims has been remaining

relatively stable. It hasn't been significantly increasing. But the duration of those income protection claims has been rather increasing, and I should say that because of that, we'll be doing a bit more analysis. We're expecting more data to come in by the end of this month, actually, which will be analysed over the Christmas period into the New Year. So we'd expect (indistinct) have significantly more and better data to be able to report to the community.

But what we can say, at the next level down, is if we look at just mental health claims, the top 10 causes of those mental health claims were 15.9 per cent depressive episodes, 12.6 per cent reaction to severe distress and adjustment disorders, 11.7 per cent anxiety disorders, 7.3 per cent recurrent depressive disorders, 3.3 per cent bipolar, 2.7 schizophrenia, 2.6 per cent is other dementia; that is, other than Alzheimer's, 2.5 per cent Alzheimer's, 1.6 per cent disorders due to brain injury, brain damage, and .8 per cent mental disorders related to alcohol abuse.

So it's interesting we starting to capture that information. That was for 2018. So that was really by way of background. I did have a couple of proposals for the Commission, if I may.

PROF KING: Yes.

MR KIRWAN: Firstly, we note the proposal that life insurers should be allowed the discretion to pay for mental health services in any report, and may I just say, that's an extremely welcome recommendation. But we would like to see that slightly modified in a small way, and that is that it shouldn't be restricted to just mental health. And the reason is that claims for life insurance policies (indistinct) are very complex and can be multifactorial, and what can start off as an injury an illness can lead to mental health the other way - the other area as well. So it's not just one fit, and so by bringing (indistinct) in that way to mental health, we feel that would be perhaps more restrictive than we would like. So we believe it could more helpful than that.

The other recommendations; we heard the recommendation of standard 21, which is that all staff, and not just customer basic staff as at present, should receive mental health awareness training. And again, that's a very welcome suggestion. We are currently reviewing our standard 21, so it's also a very timely recommendation. However, we think maybe all staff might be going a bit too far. There are some back office staff who never come into contact with customers.

But perhaps if we could suggest extending it such that people who are involved in designing the processes that customers will use, people who are designing policies that customers will have, would benefit from mental health training as well. So when they're designing those processes and products, they would have a mind to the sort of experiences that the customers might have.

So those were the main thoughts and suggestions we wanted to put to the Commission, and as a very last point, we have recently concluded a research paper which KPMG prepared for us. It's actually a literature review looking at the importance of psychosocial factors in mental health. And again, we'd very much like to make that available to the Commission. We have a link. And I guess that's (indistinct).

MS DULOY: Yes. I might comment on a couple of things, if that's all right.

PROF KING: Yes.

MS DULOY: So firstly, again, we really welcome draft recommendation 24.6, which we also supported in our submission, and it's something that we've been hoping that we can - that we're really hoping the government will join us on this, because a one of the largest supporters of people with mental health in the country, we think it's really crazy that it would be a criminal offence for us to find someone psychological counselling if they really need that. So we'd really like to see that change.

Just a really small point, you say that (indistinct) work on the pre-conditions.

MS ABRAMSON: Yes.

MS DULOY: To set that up and add preservation of the regulator for insurance, and also private insurance. So we wondered whether they should be (indistinct) as well, or instead. But that, you know, we obviously work with whoever the relevant regulator is. On a (indistinct) we agree that that needs to be done.

So you also asked in your report about what barriers there are now to providing employer funded income protection and this is a product which we offer now where employers can purchase a group salary continuance policy to cover their employees and, in fact, MetLife is the largest provider of such products.

But they are quite tax efficient the way they're offered because they're not subject to fringe benefits tax so, that is quite an efficient way of providing it. The only thing is that claims experienced in those sort of products has been worsening and there's been a lot of pressure on costs and APRA has actually been sort of saying to the industry, 'You need to make these products more sustainable,' because some of them are (indistinct words).

So that's probably the main barrier and, in fact, we've had some employers come to us and say, 'How can we make this cheaper? Could we impose more restrictions on providing the (indistinct) health benefits?' and one that actually came up fairly recently, an employer asked us they've got a 10 year benefit period; could they just have the two year benefit period for mental health. So it does seem to be an area where people look at if they want to try and reduce costs within a policy. So we could provide you with more information on that if that would be helpful to the Commission.

The other thing I wanted to mention is that we also talked in the report about the state of data in Australia and the fact that the ABS survey is now sort of old and it's still the key source of data and you've made recommendations that that be updated and (indistinct words) and we would agree with that. As the next step the ABS's been involved in a big data project to try and get better transparency by course of (indistinct) generally, not just for mental health, and we've been involved in that and we'll continue to support that.

And another area that we think is important is better access scheme has provided huge benefits, but there doesn't seem to be a lot of follow-up in terms of, well, what are the evidence based treatment that people are getting and are they being effective? And, again, if we were to be

involved in providing some of the funding for that we would like to see a bit more process and a bit more governance around that as well. So they're probably our main (indistinct). Thank you.

PROF WHITEFORD: Yes, thank you.

MS ABRAMSON: Could I just ask - thank you for appearing today - I just want to clarify one thing. The reason we'd specified that ASIC is because of the conduct regulator and we saw their role in codes but I'm well aware that ASIC of course would have to talk to APRA because it was mainly because we were thinking about conduct.

MS DULOY: Yes.

MS ABRAMSON: Could I ask you some questions about underwriting? So in determining insurance premiums, how do you assess the risk of mental illness of an individual and how do you take into account the nuances of different types of mental illness?

MR KIRWAN: So in our consultation version of the (indistinct) into the life code, we did speak to a number of people in the mental health community, Mental Health Australia for example, and they were very keen for us to improve the sort of factors that life insurance should take into account and that version of the code does say that we would take into account a history of the condition and the severity of the condition which we believe is in line with what people are (indistinct) are using now when they make individual assessments for (indistinct).

MS ABRAMSON: Can I ask, and I'll be a bit direct so I hope that's okay.

MR KIRWAN: No, please, do.

MS ABRAMSON: But how far into someone's past when an insurer - because we've had a lot of people call us - can an insurer actually look? We've heard anecdotally evidence of insurers trawling through someone's medical history on the general consent form to actually find any inserts where, 'Oh, well, you had depression after you had your baby, we'll deny you mental health cover.' So that's the type of thing that we're quite interested in the standards of the industry and how we could get, you know, to actually get those across the board.

MR KIRWAN: So that, as I understand it, and I think that accusation normally comes with time of your claim rather than when you're assessing an application for cover. But the answer is there's no real hard and fast rule as I understand it about the length of time because it does depend on the condition and some things are relevant and potentially forever; you know, sort of 'have you ever had cancer' is a very material thing no matter how long you go back and it's actually (indistinct) in the past. 'Have you ever had a headache?' Well, of course, we shouldn't go too far back on those kind of things.

So I think it does depend on the nature of the condition itself as to whether it is relevant or not. Some things are relevant for a very long time and potentially forever, other things clearly not so. You know, some things are only relevant if they're very recent.

MS ABRAMSON: I think that gets to the heart of it because it's really about making sure that the - and understanding the role of underwriting because it's a business.

MR KIRWAN: Yes.

MS ABRAMSON: But it's got to be matched with the objective facts about the condition and the person's experience of that condition. So that's really what we were getting at.

MR KIRWAN: Yes.

MS ABRAMSON: And you're right; we have heard, especially with the Royal Commission, a number of concerns about insurers rejecting claims at the time the claim is made, but the claim is just as valid for the underwriting point.

MR KIRWAN: We understand; and the industry through its code is taking enormous steps forward and we want to continue to make those steps to improve the customer experience and it's really (indistinct).

MS DULOY: Sorry, can I just jump in there? We've also recently, with the ABC, introduced the new standard on the consent form which was partly in response to concerns raised by the mental health community and other health groups which is making the consent form a lot clearer and a lot more specific.

MR KIRWAN: Yes, good point. That's (indistinct) come into effect very recently and it's a process with the RACGP, the Royal Australia College of General Practitioners and we're very pleased to have reached an agreement about that so that people are very clear about exactly what they consented to and what they're not consented to and we understand the sensitivity around consultation notes of a GP and the privacy that they have between the patient and doctor and that's why that's treated as a separate category under this new consent form, so people are very clear about very limited circumstances in when those consultation notes could be released.

MS ABRAMSON: That's a very welcomed development because one of the other things that's been raised with us is that people are delaying treatment for the fear of will it deny my insurance cover. So those type of developments are pretty important and we'd certainly welcome a written submission which outlines the notes.

Can I ask you one additional question? Is which goes to this; which is about the stigma.

MR KIRWAN: Sorry? About?

MS ABRAMSON: About stigma.

MR KIRWAN: Stigma.

MS ABRAMSON: So people are not, perhaps, seeking an insurance product because they're worried about disclosure because they're worried about what we've just talked about. But also because they don't want to be 'labelled' with some condition, and I'm just wondering what the industry's view about what we can do to reduce the stigma around having a mental illness.

MR KIRWAN: Yes, of course. I mean it's a community issue I think we're seeing and it manifests itself some clear way. So for example this data that we've recently gained access to shows that when it comes to maPROF KING claims for mental health conditions the delay in notification of those claims is more than six months longer than the average of every other claim.

So people are not coming forward to make a claim on their policy. Perhaps, it's stigma; perhaps, it's other reasons. We don't fully understanding the problems and so I don't think I've got any particular recommendations for the Commission on that, other than to note that it is obviously a community concern and it does manifest itself in ways that we can now see and measure and, you know, we would like to play our part as (indistinct) in doing what we can to address it.

MS ABRAMSON: Well, we'd be really keen on seeing that data that it's a six month period.

MR KIRWAN: We can make that data available to the Commission, we can certainly give - it applies in both income protection and total disability claims where people take longer to submit that and, of course, that's a shame that people are not working but, of course, the sooner they submit the claim, the sooner they can get that much needed financial support.

MS ABRAMSON: And, you know, you would've seen, we have a really strong need for some early intervention and the treatment they (indistinct) particularly (indistinct).

MR KIRWAN: And of course late notification is a barrier to that early intervention because if the life insurer doesn't know that the person has got, you know, a mental health condition for, you know, an average of an extra - it's not six months, it's and 'extra six months' - then, of course, it's very difficult to see how, you know, the early intervention could apply.

MS ABRAMSON: I'll also ask - - -

MS DULOY: Also, again - - -

MS ABRAMSON: I'm sorry.

MS DULOY: The recommendation in relation to delaying interest to finding health services could also help with early intervention as well, because (indistinct) say for TBB they're on a six month waiting period, if we could maybe provide the person with some support during that period. That might be helpful from an early intervention aspect as well (indistinct) important to be booked into (indistinct words).

MS ABRAMSON: No, absolutely. Can I also ask; I understand, and you'll correct me if I've got this wrong, that an insurer cannot deny cover to a person once they've made claim. There's something in the insurance contracts that (indistinct) so you make a disclosure; you make a claim. As I understand it, you can't not underwrite them for the (indistinct).

MR KIRWAN: You're exactly right.

MS ABRAMSON: Yes.

MR KIRWAN: The assessment of the person (indistinct) medical background and history and other things only take place when people apply for cover. Once you've got the policy, you're not required to make any further disclosures if your health changes for the worst in some way. You absolutely keep the cover you've got for as long as you want to.

We do have something if the (indistinct) situations occur we (indistinct) just to make clear to people that if their health improves in some way then, there's absolutely no reason why people can't come to their (indistinct) and say, 'Look, I had this condition in the past which is (indistinct) affecting me; it's been five years. Please, can you think about removing that (indistinct) or that extra premium or whatever.' But, of course, that's something the customer can choose to do if they want to, but there's absolutely no requirement or coming forward and saying, 'Look, my health has got worse in some way,' you just don't have to disclose anything other than (indistinct).

MS ABRAMSON: Can I ask one final question? My fellow commissioners are being very indulgent of me. But what about the premiums? So you make a claim on the policy and then you underwrite for (indistinct).

MR KIRWAN: Yes.

MS ABRAMSON: So does that mean that because you've made one claim your premium rate will change?

MR KIRWAN: No, no.

MS DULOY: No.

MR KIRWAN: That's actually against the law.

MS DULOY: Yes.

MR KIRWAN: So if life insurers want to raise premiums, they have to raise premiums so everybody will (indistinct). You can't pick on, you know, Ms (indistinct) has made a claim, therefore, we're going to put her premium up. That's what'll happen.

MS ABRAMSON: Thank you so much.

MS DULOY: We can only raise the rates across the board for getting the (indistinct) that's in the life insurance (indistinct).

MR KIRWAN: For the (indistinct).

MS ABRAMSON: Thank you.

MR KIRWAN: Thank you.

PROF WHITEFORD: So one question from me. So you mentioned that the frequency of the number of claims for mental health hasn't changed, but the duration of the claims has.

MR KIRWAN: We'll know more about that in the first quarter of next year and that's the early indication we're seeing.

PROF WHITEFORD: So I guess my question would be if the person is getting early treatment and effective treatment and the right treatment then, you would hope that the duration of claims would be reduced as much as possible and I noticed that some of the conditions in your list - in fact, the second is - I'm sure you know the diagnostic criteria around these - but adjustment disorders by definition don't last more than six months after the stressor that triggered it is gone. So either the stressor is still there or that disorder, by definition, has to emit.

So I guess from a clinical point of view we'd be concerned to ensure that the individuals are getting the right treatment and whether they're being treated by a clinician who, perhaps, isn't providing the optimal treatment that that individual needs. It might come to the issue about, you know, being involved in the treatment more, but do you have any data on who is being able to provide the treatment for the people who are insured?

MR KIRWAN: We don't have data on that. We do have some concerns. So around 80 per cent of the data we get is assessed using the ICD-10 codes for international classification of diseases (indistinct) to assess this - and I think we feel very confident that if someone goes through a psychiatrist and they're diagnosed, I think we would expect them to fall into exactly the right category of that particular - there's about 120 more of those categories - whereas we, perhaps, don't have quite the same level of confidence if someone is being diagnosed by a general practitioner. We don't have any hard evidence to support that but there is a question about, you know, given this long list of classifications, whether people are always in the right box and therefore the extent to which we could rely on that level of detail of the data. But that is a question in our mind, I'm certainly not making any accusations, you know, at this point, but there is a question about that.

MS DULOY: Yes, we don't have any sort of data on that too, but anecdotally we have had claimants who are claiming for a mental health condition but they're not actually receiving any treatment at the time of the claim because they've already tapped out their benefits.

MR KIRWAN: Still obtaining the psychiatric treatment.

MS DULOY: Yes, (indistinct) or if they're getting any treatment, it might be the odd visit to the GP. But it's not - there isn't a formalised treatment plan for their condition.

PROF WHITEFORD: So I guess my comment in response to that would be that the 10 sessions is the annual cap under better access for allied health provisions doesn't apply to psychiatrists, GPs and certainly in the public sector. We've been altered to the concern around the 10 cap limit and have recommendation in the draft report about that. But clearly for someone who is needing to continue to claim, one of the things that we would want to hope that optimal treatment had been provided and that if they remained incapacitated by their illness then, that everything that can be done has been done to address that. Thank you very much.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you.

PROF KING: Next, we have Irene Gallagher. Just state your name and organisation for the transcript and then, any comments you'd like to make.

MS GALLAGHER: Thank you. So my name's Irene Gallagher. I'm a CEO of Being, the New South Wales peak organisation representing people with mental health issues. Thank you, I do have an opening. So thank you to the Commissioners, the Productivity Commission, for the opportunity to present the views and perspectives of people in New South Wales who are living with mental health issues and emotional distress in today's hearing.

As I mentioned beforehand, for some background, Being is the New South Wales peak body speaking with and for people living with mental health issues. I'd like to take this opportunity to acknowledge the members of Being that we serve and represent and thank them for sharing their experiences and perspectives which contribute to our submissions and points for today.

We would like to thank the Productivity Commission for their draft report and for highlighting key recommendations which are pertinent to our community. Our members have raised a number of key items for consideration by the Commission outlined in our submissions for today, and whilst the eight points that we have noted are in no way exhaustive of what our final report will conclude, they are key items to our members and to our community.

So many have expressed to us that they feel the final report needs to acknowledge the real experiences of real people who are often stuck in broken systems or who fall through the gaps of service provision with nowhere to go. Key to the final report is the recognition of the current system entrenched with a biomedical lens with biomedical language which treats people as illnesses, first and foremost.

People don't heal in places that focus on biomedical lenses, focused on illness rather than recognition of their distress from childhood, environmental, relationships, broader community, stigma and discrimination in our society. They heal in spaces in which truly nurture and recognise people's trauma histories in ways in which we heal.

As a starting point and at the heart of the work, and hopefully the discussions that we will have ongoing for this final report, we would like the Commission to consider a fundamental factor in approaching the development of the final report. If we are to truly change the way systems and services operate we need to shift our thinking from the current dominant biomedical discourse of pathologizing individuals as though something is wrong with them; lacking, inadequate, gauged.

Our approach should always be one which questions what has happened to you, not, 'What is wrong with you?' (Indistinct) alliance with the basic human rights, social justice principles and acknowledges social determinants such as housing, finance, work, connection, isolation, poverty, racism, sexism. I would now like to discuss some of the eight points that we have noted. Thank you.

PROF KING: Yes, so just dot some of the points that you've noted. Let me start off with consumer involvement, consumer career design.

MS GALLAGHER: Yes.

PROF KING: So we've discussed some areas and some recommendations with regard to consumer codesign. What would you want to see more in the defining (indistinct)?

MS GALLAGHER: The fundamentals to any systemic change or the broader approach that I believe that the Productivity Commission is looking to take and also what's needed for our community, is to ensure the coproduction, codesign and codelivery is embedded in every aspect of the report. I don't think that we can have it in one section or one recommendation. It needs to be entrenched and underpinned throughout the report.

We know for a fact that there's sporadic mentioning of consumer involvement and engagement in the report. We'd like to emphasise the needs to ensure an overarching sentiment, the coproduction approach to (indistinct) reform system. We'd like to ensure that threaded through every recommendation is codesign and coproduction and (indistinct). We know the coproduction, codesign, co-development redefines a relationship from one of beneficiary or dependency on services to one which shares a mutuality and was positive for all involved and we believe this is a fundamental aspect that needs to be informed through this report.

PROF KING: Thank you. One other thing I'd like to touch on; you've commented on peer run services and I guess my slight confusion there is we see, and I think we understand and we (indistinct) many difficult hearings who have reemphasised - it's the importance of peer involvement and peer support staff, for someone who has been (indistinct) mental health, just being able to sit down and talk to someone who's been there and the important benefits that can create.

I get the impression that you feel that's not enough; that there needs to be something more, but I'm not quite sure that I understand what that more is. So do you mind explaining that?

MS GALLAGHER: Sure. So we don't want to devalue peer support that's on offer now, and many consumer workers that work within systems and services. We're talking beyond that. We're looking at opportunities for services that are specifically run by peers. There's enough evidence that supports the efficacy of peer support and to have peer run services and there are already some throughout Australia which have peer run services where people can be with like-minded people in an environment that's a nonbiomedical model. I think that's the key - it's a nonbiomedical model, and I know that there are some endeavours to establish almost like safe spaces in cafes. So we have the first safe haven café in St Vincent's in Victoria.

But an appreciation is that it's still based on a biomedical model; it's still attached to mental health services. How would it be if we had opportunities for people to come and visit through drop-in centres or safe spaces that people could be as an alternative to emergency departments for example, to just be with their peers to be able to sit and to talk and to share stories of hope.

It's a fundamental aspect that I think is not necessarily acknowledged and doesn't have whole strength in the current draft report. The fact that through sharing of our stories through hope, the recovery is possible, that we can heal from our traumas, to be with likeminded people. I don't think we can underestimate that.

PROF KING: Can I just follow up on that before passing it over to my fellow commissioners because the approach that we've taken, and I understand that you have some concerns about the sort of architectural approach bringing (indistinct) for psychosocial supports more broadly, is that we set up the institutions, the framework, the governance structure, but then it would be up to the relevant commissioning authorities, it could be a regional commissioning authority, with those with lived experience as part of that commissioning authority to determine what are the right services for their specific area and we've been quite deliberate. Well, we haven't said, 'They should be peer-run services,' or they should be some other form of service, and that's quite a deliberate approach that we've taken because, of course, it depends on the region. I mean that's the whole point of going and adding it on a regional approach is simply to allow that flexibility.

Now, I understand though that you've got some concerns with that and I'm worried if - - -

MS GALLAGHER: Yes.

PROF KING: Could you expand on that? Because I'd really like to better understand exactly what those concerns are and whether they're deep issues that we need to grapple with or it's partly that we haven't explained ourselves.

MS GALLAGHER: I think there's a couple of different stages there and (indistinct) if I can start off by considering the words of Professor Mike Slade who's from the National Health Service in the UK and he's been instrumental with developing recovery-oriented services, processes supporting the development of the peer work force.

Mike Slade's words, he talks about us being disruptive innovators and I think sometimes we need to think outside the box rather than thinking of the same-old, same-old and seeing how we contract administrator broaden what we already have and I think we have to be really careful that we don't get into that mindset that we actually look for alternatives, and that was part of the reason peer-run services and key-run organisations.

As far as the architecture of the report about some of our concerns were particularly in regards to national commissioning and where does that leave people at a local level, where does that leave the current peer organisations. We know that there's diversity amongst allied communities, we know that there's diversity for people in rural and remote areas, for older adults, for youth. We know that there's diversity amongst the LGBTI communities, with core communities in the forensic system. It almost seems like there's a one-size fits all approach and that's the feedback that we have received from our members.

PROF KING: Yes.

MS GALLAGHER: So how can we look a little but more diversely and consider opportunities that are a little bit more diverse rather than thinking, 'Okay, well, we'll just, for

convenience or for ease potentially, we'll sort of stick things in a national box and hope for the best almost.' I think we're not really observing fundamental needs of people, their diversities, but also at state levels.

MS ABRAMSON: Thank you, for appearing today. Thank you for taking the trouble to be quite clear about the issues that you want to raise. We really welcome a submission and especially around when we talked about national commissioning because we did see that as a role for some areas like suicide prevention when you're trying to roll out a program across Australia, we're very open so, we welcome your thoughts on that.

MS GALLAGHER: Can I just mention through the hearing? I think we also have to be careful because we're starting to see some sort of a separation between mental health and suicide prevention. So, whilst I appreciate that approach, we must also acknowledge that many people with mental health issues take their lives.

MS ABRAMSON: Yes.

MS GALLAGHER: And so whilst we have diversity through say for example mental health suicide prevention, and commissioning happens in different ways, we're already seeing that in mental health and in the mental health sector, but also drug and alcohol. But there is necessary collaborative working relationships that need to happen. So I would just point that out to the Commission as well.

MS ABRAMSON: Understand; thank you.

PROF KING: Thank you very much.

MS GALLAGHER: Thank you.

PROF KING: Next, I think we have Jac Van Velsen who I hope I have not done terrible things with your name.

MS VAN VELSEN: It's Jac.

PROF KING: Jac; okay. It was my very poor attempt to think it's a Dutch last name with a Dutch pronunciation for the first name. My apologies.

MS VAN VELSEN: That's okay.

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

MS VAN VELSEN: Yes, lovely, thank you. So my name is Jacqueline Van Velsen and I'm CEO of WISA Wellbeing in Schools, Australia. I'd love to just thank the Commission with the opportunity and also, acknowledge our traditional owners of the lands on which we are meeting. I would also like to congratulate the Commission on the great work of the draft that they've already produced.

I'd also like to start by just acknowledging education is probably one of the most important social determinants of health, as Professor Michael Marmot has indicated, and has seen first hand in the last two decades I've been working in school communities, that the life trajectory of young people in terms of their health is influenced in a major way by how long they stay in education. I know that you've acknowledged that in the report. However, our real emphasis is in supporting the most marginalised students in Australia and ensuring that the longer they can stay in education, we know we're actually changing lives and their mental health and well-being.

So our organisation, Wellbeing in Schools, Australia, is the only national provider at the moment training and support for school staff targeted specifically to enable them to effectively undertake the wellbeing role in schools. So we build the capacity and capability of school staff to address a whole school community approach to wellbeing, acknowledging that includes all aspects of health and that mental health is not separate from the other aspects of health.

We're a national not for profit; we do this with no government funding, despite numerous and ongoing requests to state and federal governments, because primary prevention and early intervention in this space has not been an area where they have invested a great deal of money.

We build the essential skills and knowledge that those school leaders of wellbeing require and we provide them with highly effective tools and resources, combining (indistinct) best practice from Australia's leading academics and practitioners with the tools to identify and address their own school's specific needs.

We've currently got a 98 per cent satisfaction rating from school staff which is of course feedback data regarding both our training and resources meeting their needs and so we have about 4000 people, as I said, that we provide this training to. So it's given us, as we've been doing this work, we've also been collecting evidence. We work closely with the school communities and education and health jurisdictions across Australia and we've done so for a lot of people for the last two decades.

I'd like to just start by challenging the draft report's concern that it is too difficult in navigating state and federal partnerships across health and education. It's something that we did very successfully with KidsMatter and (indistinct), the first national mental health and wellbeing initiatives for primary and secondary schools, something that we've rolled out across the country over the last two decades.

So we bring over 20 years of experience and expertise in implementing mental health and wellbeing into primary and secondary schools across Australia. We work closely with drug education staff who, previous to this time, had been on the ground for a decade in the 90s doing early prevention work, and they very generously shared all of the effective implementation science. So we've been developing this and can now bring over three decades of that implementation science to ensure that effective implementation into schools is part of a school's core business, not an added extra.

During our Kids Matter (indistinct) we identified a huge gap which led us to the establishment of our national not for profit organisation and that was that more and more initiatives were

being thrown at schools in this space of mental health and wellbeing, but nobody was actually working at building the capacity for people in school, predominantly teachers, to do this work.

So we decided to currently - well, we built and provided a wellbeing training and support directly with those school leaders of wellbeing, to school leadership, to school staff, to students and to parents. As I said, over the past five years we've worked with over 4000 school staff and then additional others in terms of the parents and the students.

We've also been collecting data from them on the strengths and challenges that they face in addressing mental health wellbeing and sadly, we have actually seen a number who, with no training experience, we've seen the impact accumulative of a carer's trauma and resulting in their burnout and their own mental health disintegrating.

Whilst mental health is certainly the most common issue; so this is some of the data that we've been collecting over this period. While mental health is the most common issue they address, it is not the most challenging which it was when we first started this work two decades ago. So there's been a huge shift in what's happened in schools.

Currently family custody, homelessness, school refusal, truancy are the most challenging issues. So I would agree with our previous speaker; in terms of it is an issue of facing those social determinants of health and not just looking at the mental health on its own, and sadly, some of our most marginalised students have been also quietly being exited from the education system, which really concerns us, this data that we're seeing across the country. If they're too challenging or there's too many issues, sometimes school, with a lack of empathy and understanding, quietly exit them out of the system.

We're particularly concerned by other data that we've identified. So for example the majority of the people in these wellbeing roles in the schools have been in them for two years or less, so there's quite a high turnover. The majority have no formal training to undertake the wellbeing role; they're predominantly teachers; just under half are saying that the wellbeing role is not manageable and the wellbeing needs of the students are increasing and becoming more complex, and we're seeing that right across the country; staff are not often fully aware of their legal obligations or have the essential skills and so that's the things that all of these we're addressing in our training.

A staggering 98 per cent do not know the most effective interventions to address bullying. So we've been working with our two leading international experts in this space; Professor Donna Cross from the University of Western Australia and Professor Ken Rigby from the University of South Australia, but this is a major human right abuse because Australia is the signatory to the international rights of the child that all children in Australia should be able to be educated in a safe and supportive environment, and we can clearly say, we haven't come across a school yet that this is in place and this is damning because we've got mentally, vulnerable young people and you can do all the social and emotional learning and training you like in the world, but if the places aren't safe, then it's not going to be effective.

A quarter of the staff in the wellbeing role do not have a role description. 85 per cent state that resourcing of wellbeing is inadequate in their school to address these growing needs. We know in Australia that we've got broader data in like 1 in 6 children living in poverty; 1 in 5 - 1 in 4

experience a mental health; 1 in 4 witnessing family violence; 1 in 5 going to bed hungry and school hungry at least one a week; 7 per cent of our students having a disability; 11 per cent are of a diverse sexual orientation; 50 per cent of our students are bullied in the middle years of schooling - direct links to mental health.

Also, which is really concerning, a very recent trend is - and we think this is underpinning a major increase we've been seeing in mental health issues, particularly in the upper primary years - is sleep problems in school-aged children are wide spread, with a direct link to mental health when they're sleep is disturbed regularly, and we had data through (Indistinct) Australia and other sources that show 31 per cent of 6 to 12 years olds are accessing electronic devices between 10 o'clock at night and 6 in the morning, and up to 83 per cent of those by the age of 18.

So what we're seeing, and we know that the work we've been doing with Sleep Health Foundation Australia, is that if that deep sleep, our circadian rhythm, gets disrupted during those night hours on a regular basis, there is a direct link to greater increase in anxiety and mental health issues.

So in finishing up here, together with our bullying findings and the sleep deprivation, we're really concerned about the continued increasing poor mental health, in particular, this trend moving into the upper primary school and increasing numbers. Our most marginalised young people and children are too highly represented in this data. It's not just an emphasis on social and emotional learning but (indistinct) need, it is inclusive welcoming cultures and safety that need to be addressed.

I urge the Commission to consider this data and address the social terms of health. Things like universal breakfast programs, uniform and educational learning resources being available for all students in our schools so they're not keeping silent out of shame and not turning up. We're not just throwing training and support into the online space. The evidence of best practice is blended learning; build a relationship face-to-face in our schools and our most marginalised schools, we need intensive support to build a whole of school approach to addressing mental health and wellbeing.

Yes, there is a plethora of initiatives. Schools grab the latest shiny ball and WISA likes to help them to build sustainable, whole school approach to wellbeing using their needs data, guiding them in what are effective projects and what is the evidence of best practice. We need that balance of mental health and education providers working together with schools and, yes, those federal initiatives that exist at the moment need evaluation. Please, stop throwing millions and millions at them without that having been done.

PROF KING: Thank you. I'll start with one; but possibly comes out of left field a bit. But just listening to your comments on the importance of social determinants and more needing to be done at school, and you mentioned things like breakfast clubs, uniforms; we've obviously heard about things such as the extra activities that schools charge for, and I know it differs between different states. But to what degree should we be thinking about or should this issue be thought about through the funding lens of the school. How much can change in the approach to funding the school? Is that a tool that we should be talking about? We haven't at the moment.

MS VAN VELSEN: Absolutely. The majority of the high needs that we're seeing and the escalation with mental health and we're hearing from schools is lack of resources to do this. Our current school and the focus on their NAPLAN and results, they're at capacity and we're hearing that regularly that they're at capacity.

We know that when we started rolling out the KidsMatter, Mindmatters which is now their new initiative two decades ago, we had people turning up in droves just simply because the training was free and it is a huge impairment. They don't have the resourcing, and I think if we can embed key wellbeing dollars into this space, it would make a dramatic difference, and I was concerned in the report that already, they were looking at, if they were going to appoint a wellbeing person, that it might be shared across schools and I think this really needs to be addressed on a level of need combined with the population because so many areas of need are massive and it may simply be that certain families have moved into a community and suddenly the school is crippled with, you know, extra high-needs and the resourcing and extra support they need to put in; so needs is critical.

PROF KING: Thought on how that would be made, implementable. So let's take the example that you just finished with there.

MS VAN VELSEN: Yes.

PROF KING: So at the moment to the degree that there is different funding on the basis of needs, it's done at quite a high level for schools. So it's done on SES calculations for example by post code; but that doesn't really take account of when there is, as your example, one or two families with high needs move into the relevant school zone. Is it possible to make funding flexible on that basis or do we need to come at it through another lens? Does the funding need to follow the family in that situation? Any thoughts on that?

MS VAN VELSEN: Yes, I think schools, if they are given the tools to identify the level of wellbeing needs of students upon entry and then in the subsequent years because things like bullying can happen overnight and compromise kids' mental health quite dramatically. So it's not just families, it's what's actually going on, and I also mentioned in the - how schools can become quite toxic depending on the leadership of the school, the focus on wellbeing or on, you know, purely a high-achieving academic school and we don't believe in this, you know, welfare (indistinct) you know, add-on nonsense that some people believe in. Those things can have a massive impact into how healthy the school cultures are.

So universal data collection in terms of identifying wellbeing needs across schools would give you that indication of the changing nature of schools, and collecting that data directly from students, collecting that data from the parent community and also from the staff at the school so, you know, you've got cross sources, yes, just more reliable.

MS ABRAMSON: I'm very mindful of time. So could I get you to take some questions on those? I don't know if you were intending to put a submission in, but we would warmly welcome that.

You mentioned a few sort of programs in half-sense. So we're looking for really practical recommendations that could be implementable and I know, you know, when you're talking about circadian rhythm, I know for example in Victoria, I think it's Templestowe, Doncaster, they actually have the kids in senior years starting later in the day. So practical recommendations would be warmly welcomed by us. Thank you.

PROF KING: Thank you very much.

MS VAN VELSEN: Both thank you for the opportunity.

PROF KING: And next, we have Fred Cicchini. If you could state your name, organisation if your representing one, for the transcript, and any opening comments that you'd like to make.

MR CICCHINI: So thank you to the Commission and the Commissioners. My name is Fred Cicchini. I'm the CEO of an organisation called the Better Health Generation. Our primary work is to deliver psychological and other clinical services to those that are unemployed on the Department of Education Employment schemes and those that are participating on the NDIS. We're an Australian owned organisation and we also operate in the UK.

Today, I wanted to speak about the work that we do briefly and bring to the attention of the Commission three key points. In the last 12 months our organisation would have worked with approximately 10,000 individuals on the unemployment schemes. That's both the job searches Australia deed and the Disability Employment Support deed. We would have worked with about 10,000 consumers in that same time that we were NDIS participants and taking services from the NDIS insurance scheme.

With that work, predominantly we employ approximately 200 psychologists. We are a private business and we reinvest in our staff through PhD programs which we're undertaking nine through universities in Queensland and Montreal, and soon to be the UK, specific to mental health and to the interaction between mental health and work.

We support and nurture those most disadvantaged in society. We speak a lot about mental health and psychosocial disadvantage, but they are no more disadvantaged than those that are subsistent on welfare payments with a mental health issue, that may or may not be diagnosed.

Often our clinicians with working with individuals maybe the first health professional that's ever heard a disclosure about mental health symptoms. We do this work because we understand, regardless of presenting issues, the routine of work puts people in a position where they're better when they're working than when they're not.

Being a private provide in a system that supports the most vulnerable, we have seen some structural issues that we wanted to bring to the attention of the Commission, consistent with the draft report and recommendations. Those three points are: workforce log jams are associated with registration practices through the Australian Health Practitioners regulation agency; also the juxtaposition between work, those vulnerable people with mental health issues going into work or returning to work over a period of unemployment and some of the issues that they may face.

The idea that the world of work is an environment where people can support their mental health, but often when there are mental health issues, they get trapped in adversarial systems like insurance and finally, the absence of a coordinated national strategy for those that have recognised their mental health issue, have found recovery and are living restively with mental health conditions but would benefit from a different system of monitoring, perhaps, a light touch, self-directed, potentially technology-based approach to ongoing maintenance of self-support.

Those are the three points I wanted to raise with the Commission and I'm happy to discuss them.

PROF KING: Okay, thank you, Fred, and can I come back to your point on individuals trapped in the vicarial system like insurance. We've made some recommendations in the draft report around that. One of the obvious ones is under the workers compensation claimable there should be immediate treatment - - -

MR CICCHINI: Indeed.

PROF KING: Not immediate income for the treatment to help individuals get back to work, it helps them to recover. Do you think we should go further than that? And if so - because workers compensation insurance is an adversarial system. Do you think we should go further than there and, if so, how?

MR CICCHINI: I believe that work, being a third of an adult's weight in life, may not necessarily be the trigger of a mental health issue but is a very likely venue. In the workers compensation environment you have the needs of the employer, the needs of the participant and an insurer. Whilst the insurer may be encouraged to give treatment with no liability loading to the employer, ultimately the insurers are declining more psychological claims than they're accepting. At one point, I understand, because I used to work in that industry, that up to 80 per cent of psychological claims were rejected based on the idea that it was an industrial relations issue.

Ultimately, with work being the venue, if we could provide people with an alternative to adversarial systems like workers compensation, that being the idea of self-referring through their general practitioner specifically to issues like the medical (indistinct) assessment specific to a work-related item number. The idea that somebody could recognise that work was an issue that may be perhaps a symptom of other concerns they're having and using their GP, unfortunately at the moment typically when you go into a GP with an issue and you rate work as a concern, you're likely to have workers compensation tabled as one of the issues that the GP and the client will discuss.

Our hope would be that other avenues of remedy were put into place. The idea of encouraging a mediation system as opposed to a compensation system with workers' rights. The idea of taking things out of the binary world of industrial relations and workers compensation and recognising that people could be having a difficult time at work and a difficult time elsewhere, perhaps get the support of their GP for treatment in that regard but with a specific goal, which is currently lacking in better health referrals to maintaining economic participation and work.

If we educated GPs about the psychosocial benefits of work and how they could hold people with mental health and give them competency at mastering where other environments of their life may not offer that, we might find that work becomes a safe haven for people as opposed to a battleground where they have to justify how well they are and why it was somebody else's fault.

PROF KING: Can I just follow up on the specific goal to maintain work, so in some ways we discussed issues relating about it in our draft, of course, but one of the things that was very quickly pointed out to us was the small business people saying, well, that's all fine if you've got a large organisation, so if there are issues occurring in a workplace, then people can be moved around, relationships can be changed within the workplace. But small businesses came back to us very quickly and said that's just completely impractical for small businesses. So how would you see that being done when a lot of Australians work in small businesses that may not have the flexibility?

MR CICCHINI: Again typically when the workplace becomes the battleground, we've moved past that point of structured early intervention. We've moved past the idea of speaking to the GP about broader issues and going to the GP about a work-related problem. There are programs historically like Jobs in Jeopardy where to get that support, you have to disclose to your employer and the employer has to support from time to time your application to get additional assistance. Again, if we moved away from the idea of using self-disclosure and potentially stigmatising people to allowing people to realise that they were perhaps placing their employment in jeopardy because of other issues and using links to their GP and a specific employment retention style service through clinical intervention, then we might be avoiding these issues that small business do face.

Ironically, in the work, in workers comp, it wasn't often small businesses that were sticking point, it was larger or moderate businesses where a workers compensation claim had stigmatised the claimant so much that there was animosity between them and their direct manager, particularly when it was related to bullying and harassment. One of the issues that we see is that there's very little mediation done and when insurance companies decline claims, what they fail to recognise is the fact that the individual is still employed there.

So typically we're contributing to turnover in employment and cost shifting into other insurance schemes when someone says they have a mental health issue, that claim is declined, they've got no option but rather than deal with the stigma, to leave the organisation or for somebody else to leave the organisation, many of those people find themselves on the unemployment scheme or potentially on the life insurance scheme.

So again, I think one of the points we make is in the workplace environment, if we were contributing to a better understanding of mental health and the fact that it's not an adversarial system, that there doesn't have to be somebody that is wrong when somebody else is experiencing a symptom, perhaps we could move to a place where that education keeps people supported and retained in the workplace, regardless of what's going on for them.

MS ABRAMSON: I just had a couple of questions and also some of them you might need to respond to in writing, if you wouldn't mind.

MR CICCHINI: Indeed.

MS ABRAMSON: Given your experience, we're very interested in the individual placement and support programs. They seem to have - although they are quite costly, they do seem to have very good outcomes. So interested in your experience with them.

MR CICCHINI: I would agree that the outcomes are certainly there, the cost is always an issue when we're talking to a scheme like that, as is appropriate indemnification. Perhaps the biggest issue that we have is those that join the workforce and support their own economic participation that may or may not be in that chronic zone, if you like, are people that are still vulnerable to perhaps having a change of circumstances and needing a support program like that without having the support of the scheme because they've moved past it.

What we'd look at is the idea of a systemic approach to a self-supporting mechanism where people with an acknowledged mental health issue that want to self-support and maintain the maintenance of their recovery could dial into something, whether it be a Medicare item or a similar service, perhaps using technology, which is like touch, easy access, to maintain their recovery. We often put in a lot of money at the beginning of a service and for those that are chronically unwell, ignoring that those in the middle, there's a really good return on investment by allowing them to maintain their wellbeing, as opposed to waiting for a crisis point when they slip into a system and there are delays in them getting the support they need.

MS ABRAMSON: Thank you. The final thing and I will get you to take this on notice, going in your own time, is we're very interested in employee assistance programs.

MR CICCHINI: Indeed.

MS ABRAMSON: And what you would think would be the key criteria, minimum benchmarks and also of course maximum. But if you're happy to make a submission, we would really welcome that.

MR CICCHINI: Indeed.

MS ABRAMSON: Thank you.

MR CICCHINI: Just one final point, with the Australian Practitioners Regulation Authority, we currently have a number of potential mental health professionals that are waiting for registration. We could currently be deploying up to 18 people that have waited more than three months into regional and New South Wales, places affected by fire, drought and other economic indicators.

I would ask that the commission consider whether or not there is an improvement in that particular area, whether technology and other sources, Medicare, for example, can register a clinician online using driver's licence, passport and as a registered health professional, I can use that system to get registration numbers and create new venues for my service.

When we're looking at people entering in the industry from recognised Australian universities and coming to employers that have already interned one to 200 individuals. The idea that there

would be any delay in deploying people into the market, a market that desperately needs them would be something that I think the productivity commission could look at with an idea of perhaps an improvement.

MS ABRAMSON: Could you perhaps just give us an indication of what types of individuals or qualifications, is it what types of people are - - -

MR CICCHINI: Australian Health Practitioners Regulation Authority registers all allied health and general practitioners. So predominantly in this instance I'd be talking about psychologists. For example, the average occupational therapist that we employ takes about two weeks to receive their registration. The average psychologist is now blowing out past three months. These are accredited degrees from Australian universities. These are individuals that have passed all the requirements, have been given a supervision plan from an organisation that's done hundreds of these in the past and the delays are there and the delays are systemic and industry wide, as we understand it.

MS ABRAMSON: I see, thank you.

MR CICCHINI: Thank you. Thank you very much.

MS ABRAMSON: Thank you.

PROF KING: Thank you very much. Just before I pass over to (indistinct), I have a plane to catch at about a quarter to - well, I (indistinct words) getting on a plane at a quarter to, so my apologies that I won't be here this afternoon.

MS ABRAMSON: Thank you, Stephen. Could I call the Australian Services Union, please. And if you could be kind enough to say who you are and where you're from for the purposes of the transcript.

MS WHITE: Thanks. My name's Linda White, I'm assistant national secretary of the Australian Services Union, which is the largest union for non-government social and community services workers. I have with me a number of people, including four workers from the non-government social and community services sector, who will introduce themselves briefly because it's important - we think it's important that you understand their kind of experience. They're not here representing their organisations and they may not disclose that on transcript but they're here representing us and other workers in their sector. Also I have with me Jan Primrose and Leon Wiegard, who are both from the Australia Services Union. But if I might ask starting maybe down that end, Robert to -

MR HABEL: Yes, Robert Habel. I'm from South Australia, in Adelaide, and I work for a large NGO and I'm a mental health community support worker and I've worked in that industry in the organisation for 19 and a half years. Thank you for the opportunity to talk.

MR FARR: My name's Nicholas. I'm from Victoria. My background's in education but I've been in mental health for the past three years. I've worked in MHCSS, with PHaMs, I've worked in as an NDIS support coordinator for a while and now I (indistinct words) services.

MR COSTELLO: Hello, my name is Cormac Costello, I work for a specialist homelessness service here in Sydney. So I come from a psychology graduate, worked in community mental health in London for many years and more latterly worked in mental health here in Sydney and now in homelessness. So my site is in a sort of outreach, meaning we go and engage with rough sleepers in the city of Sydney area.

MR DOWSETT: My name is Liam Dowsett and I have worked in the sector for eight and a half years, first as a peer worker in the Personal Helpers and Mentors Program and that program was closed down or slowed down due to the roll out of the NDIS. I moved to a state-based program, which is the HASI program, the Housing and Support Accommodation Initiative. So that's where I am now. I've been there for two years.

MS WHITE: So I should also mention that the ASU has significant numbers of member in the disability sector and we are pretty familiar with the operations of the NDIS. What we would like to cover today is kind of our view of the frame of the report, we obviously would like to talk about workforce and your question about rebuild or renovate. We have some views about PHNs, which is in our report and we've got a couple of other matters if we have time that we would like to address, if that's okay. So I might ask Leon to give you our view about the frame of the report.

MS ABRAMSON: And can I just ask for the benefit of the participants and you've been very helpful so far, with the acronyms, if you'd be kind enough to spell them out, which you've already done. Thank you.

MS WHITE: Thanks.

MR WIEGARD: Okay, thank you. Leon Wiegard, assistant secretary, Australian Services Union, Victoria, Tasmania branch. So we thank the commission for their draft report. Just some overall observations. So the psychosocial community workforce is in crisis. Both state and federal governments have removed hundreds of millions of dollars of funding as the NDIS was rolled out. In Victoria alone, 1,300 community mental health workers have lost their job and that's just from the state government funding cuts alone.

The NDIS only covers about 10 to 20 per cent, that's where 20 per cent is being very generous, of those with psychosocial mental health challenges. So in short, the NDIS is not a great fit for those with psychosocial mental health challenges. The participants our members see have serious mental health challenges but are considered to be in recovery, not disabled. And as such, the NDIS is not a great fit.

The work ASU members do links the mental health system together with the participants without the asserted outreach, which was just mentioned before, and the linkages to the community and to employment and then the rest of the mental health system (indistinct), but they're the sort of services that our members provide that are being cut.

We believe that the community psychosocial sector needs to be built up and not torn down. We further believe that the system is, as a structure at the moment, almost guarantees that those with mental health challenges have nowhere to go until the mental health issues are so acute that they need the support of clinical services. This is both traumatising for the participants,

it's very expensive and as we've just said, we've had thousands of really experienced, qualified, passionate mental health - community mental health workers who have lost their jobs.

So we think that we need to put an absolute priority on the early intervention and recovery space, not just provide ongoing clinical supports to those who get unwell enough to need them. We hope that the commission can recommend as part of its ultimate findings that we should put a primacy on early intervention and recovery based systems and not treat the community mental health space as an afterthought, as it has been treated in the past in the way it's providing funding, when you've got some cutting it when you save some money.

So we hope that we can have a bit of a rethink about the way that the system is structured in itself and not just put all of our eggs into the (indistinct) basket.

MS WHITE: So that has played out in other states and Robert, exactly the same thing, and we put an example of one provider in South Australia, how they achieved significant numbers of jobs. Robert works for another provider and they are struggling on I guess in relation to the work that they do. I might ask Robert just to give you an understanding of how they are struggling on.

MR HABEL: Sure. I've worked in the sector in a number of outreach mental health programs, we do psychosocial, strengths based, recovery-based work. I've worked there for 19 and a half years and I've read the report but I couldn't find my job in the report. That was the first point I quickly wanted to make. There's psychiatrists and mental health nurses, peer workers, but no community mental health workers, no support workers or no psychosocial rehabilitation workers, which sometimes is what the title is called. So I'd love to have my profession acknowledged in the report and in South Australia there's hundreds of hundreds of community mental health support workers working in that field every day.

In the organisation I work for and others that I do know, we've been struck with funding cuts and the elimination of programs like PHaMs and PIR. We've also had state government cuts of 25 per cent for our psychosocial programs for state-based services. And that means a reduction of a large number of people that have had to take voluntary redundancies. So we're losing well experienced people that have been around for a long time, that have got those relationships with our clients.

We're finding that long term relationships with people with psychosocial needs is the best way to work because it keeps them out of hospital, it's a good early intervention model as well and to go to an NDIS only funded service is impossible to structure workforce around that. It's not like for like funding and it's certainly not like for like work philosophically.

While NDIS is terrific and great for a number of people, we're predicting, as Leon said, up to 20 per cent of our people will qualify and get NDIS. We've got 80 per cent of people that we support won't qualify for the NDIS and it's probably not suitable for them anyway because it's a deficit model, it emphasises your incapacities, where a psychosocial outreach model works with people's strengths, their ability to recover and to work alongside people on a recovery based framework.

So we're having difficulty at the moment along - we've got a lot of NGOs in - (indistinct) got a permanent workforce, that is well-funded, it's well paid and we're struggling to find funds for training and for supervision. Without supervised small teams with collegiate support, it's very difficult to provide good services for the clients that desperately need them. Thank you.

MS WHITE: So certainly on workforce, Robert's highlighted one of our key concerns that is in the mental health workforce section, it doesn't talk - and we're cognisant that there is a chapter about psychosocial issues but the workforce actual chapter does not detail the sort of work that is done by significant numbers of our members and if we had a criticism and/or suggestion, we would like to see some - that expanded significantly so that there is some. Because what we find is that there are numbers of workers in this - performing this work but the recognition that they get, you know, and the acknowledgment of the work is sometimes overlooked.

We've made a submission to the joint standing committee about this in 2018 and expressed our significant concerns about PIR and PHaMS being disbanded and we supported the recommendation that you highlight in the joint standing committee report and the way in which it finally was extended, those schemes were extended, was knowing the damage which is highlighted in our submission, of course knowing the damage to the workforce which has not recovered. So we certainly would like to see a workforce, and we understand that peer to peer there is a specific recommendation in relation to peer to peer and we have a couple of comments on that if we might make that, and Liam has been a peer worker and might just have a few comments.

MR DOWSETT: I might just say that - to remember the not for profit sector or the community managed sector when talking about peer workers because there's a lot of peer workers in that area and often they get excluded where the training - for training and things like that. I know that because of the pressures on the community sector training is one of the first budgets to be cut and I know that if we had some sort of (indistinct) training system where the peer worker had access to make decisions and empowering the peer worker to make decisions about their training, including not just peer workers but all workers in the sectors that would be a very enabled tool to keep the skills in the sector. Also it mentions in the report seeding - possibly seeding a professional organisation.

Again, that would have to be open as well not just to peer workers in the hospital system but also peer workers in the community sector. They often get overlooked for training and things like that. I know Being is a very good program for peer worker training and peer workers and days for peer workers in the hospital system to discuss their ideas and things like that. There's (indistinct) specific for people in the hospital - peer workers in the hospital (indistinct).

MS WHITE: And we - there are a range of peer workers in a variety of areas, not just mental health and Leon has some significant experience in that in other sectors and we just might - and he might just share that with you briefly.

MR WIEGARD: Yes, I think - I mean the idea is an interesting one about setting up a professional body and we would argue that we are a professional body for peer workers across the community services sector. We represent peer workers across a whole range of different areas. We have members who are (indistinct) workers who have - who have a whole number

of other issues with (indistinct) so we see that it would be interesting to see the relationship that you see between professional organisations funded separately because a lot of the issues that we see are industrial in nature. You know, it's the peer workers are employed and then there industrial issues that may stem from the challenges that they may face and that's where you'll often find this conflict.

That there needs to be that industrial overlay between employing a peer worker and their ongoing satisfaction of work. So it'll be interesting to see how you would see that that which is (indistinct) there'll be (indistinct words) a number of worker who are already members of ours and we represent on a daily basis.

MS WHITE: Can we also speak I guess about PHNs and how that's been operating and how that has - the sort of failings that we might have seen as - and I might ask Nick to - just because he has experience with that, I mean PHN.

MR FARR: Yes. Thank you. So in 2019 federal PHaMS funding ceased and that meant that most of - - -

MS ABRAMSON: Would you be kind enough just to say PHaMS is for the transcript?

MR FARR: (Indistinct) programs that (indistinct words) - - -

MS ABRAMSON: Partners.

UNIDENTIFIED SPEAKER: Personal - - -

MR FARR: Helpers and Mentors. So many of - so most of my colleagues moved on by then and found other work. There was - like we had skeleton crew that hung onto that end date. I was - I was one of those people and I was also lucky to get a role in one of the PHN funded services. So I was able to support consumer (indistinct) transitioning from the funding stream that they were on to whatever funding stream they were eligible for, whether that be continuity of support or psychosocial transition or the psychosocial support service. I guess we were lucky that we were able to form a team that was quite experienced and therefore were able to hit the ground running, but what we're just experiencing now as there's more demand that recruitment has been - it is very difficult to find high quality candidates for these positions as they've, you know, started looking for new work way back in 2016 when the NDIS started rolling out in different areas.

I guess another issue is we're working with, we're working in a much larger catchment area with a much smaller team, and we're travelling a lot more, and I guess when it comes to PHN I think we're really lucky that the relationship is good, but what we're seeing is that there are different eligibility requirements from different PNHs, and just for one example in one PHN catchment the consumer will have to (indistinct) NDIS access and be denied before they're able to enter service and in others that's not the case. I guess another issue that we're seeing is that there has been some delays to fund some of these services, but the expectation is that the services are up and running quickly so there's been discrepancy there.

MS WHITE: Thanks. So the other on this matter that you asked organisations whether it - whether you prefer the (indistinct) or renovate model, and we have a view on that. I might ask Jan maybe to talk about the funding model first and then Leon will talk to you about that view about the rebuild or renovate.

MS PRIMROSE: Thank you for the opportunity. The concerns that I raised reflect the concerns that have been raised previously and in fact (indistinct) concerns that are raised in your own report, and that is when we look at whether to rebuild or renovate. The concern relates specifically to linking funding to existing medical funding. So that it talks about funding allied services based on funding that already exists, and the concern would be threefold. The first thing is the commitment to a medical model of psychosocial support, whereas we know that a lot of the people who work in psychosocial support in fact are professionals that don't come from a medical background.

The second thing is that linking an already underfunded sector to funding for only medical professionals is going to exacerbate an inequity that already exists, so particularly in regional and remote communities or in communities where they don't have GPs who bulk bill, and when there is a high level of people with mental health issues that either can't or don't access allied professionals or GPs or other medical practitioners. There will be no - that provides no basis of assessing the need in that area, and the third is that because psychosocial support is aimed at recovery and is a strength based approach rather than a medical deficit approach, it means that many of the people who are already accessing - who are accessing services other than medical services won't be identified.

So it's not so much a comment on whether we would prefer rebuild or renovate, but if there's a flawed funding model it's going to exacerbate an already underfunded system.

MR WIEGARD: And I think some of the more practical considerations are also that, you know, we don't - or (indistinct words) when we say that - when (indistinct) say the social sector is in crisis and we have lost a huge number of workers and there's been a number of people who have lost those services. So we see that there needs - and we understand that there has been some stop gap funding but that's really just tinkering round the edges. If we're going to - I don't think there's many people who would say that the mental health system in this country is working particularly fantastically well. So a rebuild is something that we have to absolutely look at. But I think we need to have some stop gap. I think one of the recommendations that we have is that Personal Helpers and Mentors, Partners in Recovery (indistinct words), these programs we know have worked in the past, being refunded until such time as we understand what that rebuilding is like. And what we're concerned about is if we are going to spend the next year or two picking it apart and rebuilding and then working out what funding ought to be, we'll be losing the services.

I think one of the reasons why Nich's service has worked particularly well in Victoria is there wasn't much of a gap between the loss of the funding and the state funding that came through to replace some of that. And they were able to transfer the workers just directly from one funding scheme to another. And so they kept those professional workers.

The longer it takes for us to rebuild the system, the more we lose those people who are already working. There are many who are being lost and moving to other areas like alcohol and other

drugs who probably won't come back because the system is not – you know, because there's been so much change and so much chaos. That's not exactly the system that people want to come back to if it's going to take another year or two. So, some of those practical examples, yes, help to rebuild, but we think there needs to be a stop gap (indistinct).

MS ABRAMSON: Can I perhaps ask you to pause there because we're very keen to ask you some questions.

MR WIEGARD: Yes.

MS ABRAMSON: And we're also working on the basis that you'll be providing a further submission and having further conversations with us. Stephen, did you want to ask something for (indistinct)?

PROF KING: There are a number of things that I could ask. I just want to clarify actually something that (indistinct) mentioned. You talked about a portable training system for peer workers. Then for community health workers, you made some comments on – which I wasn't quite certain about. Were you talking about the training system for community mental health workers needing to be – improvements there, accreditation? Do you mind just expanding a little on that?

MS WHITE: Sure. We commissioned a paper done by the Australian Institute which we didn't submit, but we're happy to do, about this for their – for the NDIS and we gave that to the Joint Standing Committee and the (indistinct) Government for quite a while. What we see is that the training should attach to an individual - well, what we put is that it should attach to an individual and that based on the number of hours that they work in a – in a - in the sector. I'm happy to put that to you – to you - - -

PROF KING: That would be good, yes.

MS WHITE: And it is not just for peer workers. But we pitched it in relation to disability workers more generally, but it could work potentially in other sectors. So it really is then for – for the worker to amass the hours and sometimes the workforce currently, particularly in disability, people have multiple jobs and so it doesn't make sense that – well, the (indistinct) would like to see every employer do it by the funding model. Particularly in disability, then – and growing elsewhere. It means that – that is the first thing to go. Whether it's for peer to peer workers or for anybody.

They don't get the training. And that is – you're not going to have a highly trained workforce that have got the – can – people that are going to stay in the sector unless you can attach to them – unless you give them training and give them some sort of career path. And so that - it could potentially be adapted here and we have been – the Joint Standing Committee of the NDIS recommended it to the Government, that this is something they should seriously look at. So we're happy to put that, too, because we can see it elsewhere, because what's happening is that on funding training, they're not funding any work or anything under the NDIS.

And they're putting people on, as our submission says, on a lower level on their social community services award. Some might call that wage theft. I probably would, too. It's a

pretty despicable thing to put – you know, that people are performing work at one level and being paid at a much lower level. And not getting trained, so we're happy to put a supplementary submission that goes to that.

PROF KING: That would be good.

MS WHITE: Because we've done a lot of work on that.

PROF KING: That would be fantastic.

MR DOWSETT: Can I just quickly say - that I was just – with the peer work, I was just comparing people in the government hospital system. What training they get there as to what you get in the community based mental (indistinct).

PROF KING: Yes. I understood that. It was more the order.

MS WHITE: Yes. And we've certainly done more work on the (indistinct).

MR DOWSETT: Yes.

PROF KING: Okay.

MR COSTELLO: Do you mind if I say one thing?

PROF KING: Please.

MR COSTELLO: And I'm very aware of your time, is at a premium. One thing that I suppose I didn't really see and haven't heard so much as just the maybe lack of emphasis on care and treatment for trauma and it's under the NDIS again, there aren't really pathways for somebody who, in my work probably 80 per cent or more, the people I would see have mental health difficulties.

But also 80 per cent would have experienced childhood trauma or complex trauma and as a result of that, would probably have alcohol and other drug or other addiction. It's sort of all bound together. Because NDIS requires – not only does it require you to admit that you have a disability that's unchanging and not – without a possibility of recovery, it also requires you to say that all of the therapies or all of the treatments have been tried and so I have to – yes, the possibility of any kind of recovery is not there, because if it is, then that is - becomes a medical issue and it becomes a responsibility of the Department of Health.

So as a result of that, if I have those three things: trauma background, AOD stuff, mental health difficulties going on, the only recourse for me for some kind of treatment is medical treatment, which works for some people. And it does work for a lot. Or if I'm lucky and I have a care worker who maybe points out to me that there is a GP care plan system whereby you can have a GP mental health care plan and you have access to maybe six, or maybe if you're lucky 10 sessions with a psychologist or a counsellor, it's very likely, that counsellor is CBT trained, which is cognitive behavioural therapy, works for an awful lot of things, there's great evidence to suggest it does.

There's no great evidence to suggest it works for trauma. And honestly, I can't overestimate how important the kind of levels of trauma that there is in the people that I work with and that's not being catered for. So that means more trained trauma therapists and that means a kind of a systemic shift in looking at – because if I'm a trained – if I'm a, you know, a therapist and I want to be trained in something that I believe is real and useful, I'm probably going to want to go to trauma therapy.

MS ABRAMSON: Can I just - - -

MR COSTELLO: But if I want to make a living, I'm probably going to be going to CBT because that's the system.

MS ABRAMSON: Can I just ask - - -

MR COSTELLO: Please.

PROF KING: I will just give my apologies again, because I do (indistinct).

MR COSTELLO: Yes.

MS ABRAMSON: It's not that – we're just a bit mindful of time and as I said, we're fully appreciating that we will have further discussions with you. One thing I did want to ask was about the mental health community workforce. One of our difficulties with the report, we never wanted to give the impression that it was all about the clinical model, but when we looked at it we could see what the clinical model looked like and one of the difficulties with our team was that they – it's such a broad category, these community mental health workers.

So we really need some help from you in working out, well, who are these people? What do they do? What is your data around that? So we would – you know, and what's being measured - we'd really welcome that in a submission. It's an area where we need some help.

The other issue I would ask you is that what would be your criteria for access to psychosocial supports? Because at the moment we think about them, well, clinically over here, you have this diagnosis and you need X and Y. So we're very open to your views about what criteria you have around access.

MS WHITE: You said you wanted a comment on that last submission now or do you want to - - -

MS ABRAMSON: That would be – no, well, both. If you're able to comment now that would be helpful.

MR COSTELLO: There are kind of gaps in terms of - there's – there are programs that exist where if, for example, I have had many hospitalisations, mental health hospitalisations, I'm probably relatively well-covered by what was mentioned already, HASI, which is in New South Wales at least, or a very – another (indistinct) called EACLSS which is essentially called

community living support. But for – to have access to that, I need relatively recent and many hospital admissions.

If I'm struggling with mental health, but I don't have those because of the kind of, you know, death of PHaMS and now PIR as well, there's a big cohort of people who are out there who don't have casework support and who neither have the kind of support that allows for connection and community. So I work with lots of people who might have been previously homeless, now they're housed, have mental health difficulties but not enough to get onto the radar of community mental health and case management.

So to answer your question, I think there needs to be referred pathways where you don't have – you don't have to have a lot of admissions and psychiatric diagnosis but you are clearly struggling with mental health and access to perhaps a case worker but also access to just recreational stuff; connection. Because the enemy of positive mental health is isolation and loneliness and lack of stimulation. All those things.

MS ABRAMSON: Well, we welcome some thoughts in that area. The other thing that I wanted to ask about before I pass to my colleague was I think Leon, you mentioned a primary early intervention and prevention. So I'm just asking in a practical way what type of recommendations would you be looking for us in that area? I may have unfortunately got the wrong person but I think it's (indistinct).

MR WIEGARD: No, that's okay. I think I can throw something like that to Nich. But I think we've seen funding (indistinct) but I think it goes to what was just said before about people who are, maybe right at the very start and maybe just have some challenges but don't have a diagnosis and yet there are no supports available there, and so you wait and you wait and you wait until that person – until the mental health challenge gets so acute that they end up in a clinical setting somewhere.

We think that there needs to be more funding at that early stage in order to provide those supports and those linkages so that people don't end up being traumatised and end up in a clinical space which is traumatising for the participant, also, really expensive as well, and we think it's a false economy, because you're taking money out of that early intervention space in order to provide funding into the – into the clinical setting.

Nich, did you want to add anything?

MR FARR: Yes, I just want to add that the eligibility of criteria for our service is we know it's relatively low. You don't have to have a formal mental health diagnosis, you just happen to have significant mental health issues that is having an impact on your psychosocial functioning.

I guess – and so, folks can self-refer. So I've referred (indistinct) from seeing a 1300 number and making that phone call. Some recommend through GPs. I guess the issue with that and that the dismantling of the workforce is that we've gone out to a – to a three to six month wait list in three months just because we don't have the capacity to take on all the referrals that are coming in. So the wait list is already quite significant. Unfortunately, we won't be able to provide support until other people are exiting.

MS ABRAMSON: How do people find you? You just talked about referrals so where do the referrals come from?

MR FARR: Yes, so we did a little bit of service promotion. So we went to different local area community centres and community clinics, but a lot of (indistinct) so one might get support through our service and then talk to their friends and – but also, we have a lot who come through GPs and - - -

MS WHITE: And Rob, did you want – you’ve got something to say about that? You’ve got something similar?

MR HABEL: Yes, I can only reiterate what’s been said. But one – one of the great things about the Personal Helpers and Mentors Program, the federal funded program and similar programs in the State was they were basically self-referral programs and what that meant was the programs that my agency had had before then, you had to have hospitalisation. You had to have a care worker through mental health and you pretty well had to have a mental illness that was treatable by drugs.

Now, this excluded people who were borderline and other personality disorders, anxiety, depression, post-traumatic stress disorder, people suffering from refugee traumas as well.

So a self-referral program, I think, is essential both at State and Federal level and that is some – that’s one of the access that’s been shown up with this collision between the over-expectation that NDIS will fulfil the needs of everybody in current mental health programs.

Clearly, we need parallel funding of programs; NDIS was great for some people. The large amount of people that we support with mental health do far better and they prefer themselves to be on lots of other programs that are easy to access.

MS ABRAMSON: No, I understand you. But, Harvey?

WHITFORD C: Yes. So I think what you’re describing is some of the challenges we’ve heard repeatedly, that this – that the non-clinical spaces which has sometimes got this psychosocial label which means different things to different people as far as we can detect from talking to different groups, is covering a multitude of service types, I guess.

And whilst it may seem like we’re, you know, categorising it, we need some sort of structure or architectural taxonomy that describes these components. Because if we’re going to try and fund them, we’re going to need to describe what they are and who they’re for and why they’re needed and what outcome we’d get from them, et cetera.

Has there been anything you’ve come across that could help us in that regard, as far as the - there’s a further – (indistinct)?

MR WIEGARD: I’m not quite sure. But just to back up your point though, it’s funny, when you talk about members of our – the programs that have been lost and then a, ‘Do work for in Personal Helpers and Mental Services or PIR and the Victorian State Base Emergency Assess

Funding model,' and they say 'Oh, I don't know,' because it's all essentially the same service. I mean, they're doing the same sort of things and so we're really talking about the loss of those linking programs that are sort of things that we've told people to look into in the community.

So we're really talking about the - what they do, not the program model. So I guess that's what we refer to when we're talking about psychosocial is to provide those services, those early intervention and all of the suite of services that we've been talking about, in terms of what that actually looks like, I'm not sure, apart from to whole-heartedly endorse your recommendation 4.1 around finding more funding (indistinct) we'd absolutely endorse that.

I think it's good for employers and it's good for the workforce. It gives them some security and that will be security for the first time in a long time. This is a second that's (indistinct) as I said before. So what that looks like is – if you can perhaps give them a (indistinct).

MS WHITE: Yes. I mean, what we'll do is give you the - we'll give you the (indistinct) because we've got lots of people who work in that area and who've seen things that they've said to us that they think is – that have worked and the services that they provide and there's a commonality between states. And obviously – and we were – our members were absolutely in PHaMS and PIR and so we will turn our mind to that because we have got people who have worked on that absolutely.

You asked a question about the statistics. We'll try, but unfortunately, some many years ago, the ADS stopped looking at those statistics – categorising that this work - - -

MS ABRAMSON: Ms White, you might encourage us to ask the ADS to (indistinct).

MS WHITE: (Indistinct) I have encouraged the previous Productivity Commissions to do so, and so I'm happy to re-encourage and also even raise it directly with the Government because it really does, when you do contracts that are outcome based it would be helpful to know how many people it took to get the outcome and how many have done a lot of work on the Equal Pay case under the (Indistinct) Award which covers our members.

I was (indistinct) gobsmacked that nobody could tell us how many people were working in the sector. Nonetheless, the best - there is some place where you could get that and the best places is – as a model, at least what sort of workforce there is, is the ACT (Indistinct) Long Service Leave. And they have been able to – because - - -

MS ABRAMSON: Because they need to pick people up for the (indistinct).

MS WHITE: They do. They have got it, so they will give you a lesser model and what was surprising in the statistics that they generated is how many people that there actually are. And that would be a good (indistinct). Victoria will have that probably in a not too distant future for some numbers. But that would really help you seeing (indistinct). And that's the best that I've seen.

But we will work – we have made some (indistinct) if you (indistinct) through the equal pay (indistinct) attempt to get back to you.

MS ABRAMSON: Thank you. There's one file I'll ask you to take while (indistinct) I'm sorry (indistinct).

MR WIEGARD: I was going to say there's an independent evaluation on my program, the HASI program. It's (indistinct) program.

MS ABRAMSON: Our staff will be very interested in (indistinct) evaluation.

MR WIEGARD: It's done by New South Wales University, the (indistinct). And it's called the – it's just plainly called the evaluation plan, community based mental health programs, CLS and housing accommodation (indistinct).

MS ABRAMSON: (Indistinct) and kind enough to (indistinct).

MR WIEGARD: Sure.

MS ABRAMSON: So can I also ask you to take on notice, you made a (indistinct) comment about the PHNs and where you see those worked well, what do you think it is about them structurally or people-wise that makes it a (indistinct) interesting. I'm sorry it's been whistle-stopped choice. Send your evidence in.

UNIDENTIFIED SPEAKER: (Indistinct words).

MS ABRAMSON: Thank you. And we'll now adjourn for lunch and be back here at 1.35 again, yes..

LUNCHEON ADJOURNMENT

RESUMED

MS ABRAMSON: Well, I might make a start. If I could reconvene the hearing please and I have some - this morning Commissioner King noted that in an event of an emergency requiring evacuation of the building apparently we evacuate to Hyde Park. Also could I remind participants that we're actually doing a live stream. If you don't want to be in a live stream you will need to not be in the room.

We've also got psychological support here. If at any time anyone feels distressed please contact one of our staff members and Ros is at the back of the room there and we can direct you to the support we have today from Lynne. So having said that could I please ask Mr Bartlett, or Dr Bartlett, to take the stand and to announce on whose behalf you're appearing and where you're appearing from. I should have called you clinical associate professor.

DR BARTLETT: No, that's quite all right. Doctor's just fine.

MS ABRAMSON: Thank you.

DR BARTLETT: I'd like to thank you for the opportunity to be here. I'm representing the University of Sydney and the Woolcock Institute of Mental Research. I come here today with three (indistinct words) a registered nurse, English trained midwife, a PhD from Sydney University and I've worked as a health psychologist in sleep.

So what I'd like to do today is actually present to the (indistinct words) of the importance of sleep across the lifespan and particularly in relation to mental health. So sleep occurs every 24 hours a day and it's a time for us really to chill out, not to be responsible, not to think or feel, and when we don't experience this we are often compromised in terms of performance outcomes (indistinct words).

A symptomatic review of mental analyses, which has just been published this year, found that insomnia is a significant predictor for the onset of depression, 1.3 odds ratio; anxiety, 3.23 odds ratio; alcohol use and psychosis. And the author stressed the need for more prospective studies, long term intervention, and to remember that sleep provokes mood and neuroplasticity. We also know that there's a very strong bidirectional relationship in relation to insomnia and depression and this one is published in 2012 and this was of nearly 25,000 participants so if you get the baseline insomnia is not treated you will end up with depression. If you get a baseline depression and it's not treated you will end up with insomnia.

So it's been a bit shift because prior to 1996 if you had insomnia you just had depression, fix the depression and sleep will go away (indistinct words). So sleep is important across the lifespan, if we start with a perinatal period more sleep is (indistinct) with pregnancy making nausea, morning sickness, increased heat as the baby grows, baby effort unplanned outcome like a long labour or caesarean section, maybe a baby that doesn't (indistinct words) and yet an antenatal prenatal care this warns nothing about the sleep of the mother and there's certainly nothing about sleep with the baby and what to expect and really if you learn about sleep and the difference between quiet sleep and active sleeping babies (indistinct) babies that were sleeping better and what can mothers (indistinct) as well.

So when a baby is born a mother is born who equally needs parenting protection and it's the overwhelming fatigue that keeps with short disrupted sleep and wanting more disrupted sleep, it is so difficult in its first few weeks. I usually describe the first 6 to 12 weeks as a survival course and it puts a lot of stress on family and relationship dynamics and so people are isolated these days without any friends.

We know that postnatal depression occurs in 15 per cent of the population (indistinct words) and we know that if a mother is depressed - sorry, and we know that if a mother is depressed it's an increased risk factor for her partner as well. And we know that we can help this because we've done interventions at Sydney University where we've given sleep interventions for new parents and there's no difference at six weeks because it is a survival course but I - four months' intervention, all were sleeping better, they were less fatigued and they felt as though they were managing the babies better.

So I've watched some of the other presentations by child psychiatrists and the issues of involving mental health nurse training is critically important and I'm totally supportive of all of this. But we also have a lot of babies and young children in long day care. They're tired

and they're not getting to bed early at night so that's another big problem that we have to face. And the role of worry and anxiety around day care, family, school, environments but when we hit adolescents it's the perfect storm; increased homework, staying up late, phone, social media, hormones, mood, plus a certain percentage of adolescents will develop delayed sleep phase disorder where they can't go to sleep till about two in the morning, can't get up to go to school, or university or work.

Adulthood has its own problems as well in terms of sleep; working, maybe studying, travelling long distances, shift work - 20 per cent of our population are shift workers, high pressure jobs, parenting, long hours. Middle age, our bodies start to slow down and don't work as well. Often increasing weight, perhaps the onset of obstructive sleep apnoea and left untreated it's a risk factor for cardiovascular disease, diabetes type 2 and depression.

We also have other significant factors; the role of menopause on our sleep in terms of women and that can be very difficult along with actually having to care for aging parents; costs, worry, all of it very difficult. Over 60 years of age there's increase in health-related factors and we often end up taking a lot more medication, there's a lot of interaction with that that also impacts on the quality of sleep. But we know if we are healthy in terms of exercise, diet, and we need to be stimulated; the prevalence of (indistinct words) and that population is much the same as the general population. That's the big gap.

Increasing age has a more definite effect on our bodies and our brains. We know the critical role of sleep and helping to clear up the toxins that build up over the day particularly in terms of (indistinct words) which is associated with the onset of dementia and that's not been clear from the brain at night during sleep. And there's been very little research in this area until recently. Again there's a tendency to overmedicate our older Australians and to prescribe hypnotics because they don't understand about sleep, that waking is normal. We need to reduce falls and confusion and there was a lovely article in the Australian on Friday about the role of dementia which it seems quite a long paragraph on the role of sleep.

So all of these things that are happening, we've also got a drought and we've all these terrible fires; how can we help to improve better access to mental and (indistinct) help particularly in rural communities. They're financially stressed, there's isolation, there's a lack of access to care, high risk of suicide; all of these impact on sleep and sleep impacts on the way we act and perform. We need to normalise sleep and that means about giving good information out to the general community; waiting it's normal, everybody waits. It's the length of the wait that's distressing. We don't spend the night in deep sleep, we spend most of the night in relatively light sleep. REM sleep is not deep sleep and we have to know all about these things so that we can normalise them.

So in terms of recommendations, sleep being a primary component of all prenatal programs, we have good pilot data on the effectiveness of such an intervention and we need to expand programs that are already there such as organisations such as 3Bridges which is here in Sydney where they train volunteers in providing practical help, shopping, assisting mums to go to psychology appointments, in house respite for mothers to allow them to sleep and supervision of older children and this is so important with people who are isolated. These early intervention critical support of bub and mothers in early months, it's something that we really need to make more use of.

Education on initiatives on how to make good sleep fun to do with school age children. There's a paper that's just been published in Ireland about an intervention for school age children and it's all based on Australian research which is very interesting because we're not making enough use of it. We need to train practice nurses in the community, particularly in rural areas and practice nurses have wonderful motivation skills. In a pilot study we trained practice nurses to do cognitive behavioural therapy for insomnia and there were significant improvements in sleep outcomes at three months and (indistinct words) caught up at six months. They were also well supported by GP practices which is another important component when you put anything into practice and we need to make sleeping an integral part of psychology training because it isn't at the moment and we're not working on a joint venture with the Australasian Sleep Association in psychology modules on insomnia.

GPs still do not refer their patients to psychologists, they still - on average 94 per cent will give them a sleeping medication and this really hasn't changed from a paper that was published in 2010 and a follow-up in 2017 which is of concern here. We need to use other health professionals such as pharmacists because they can often be the first step and put information around sleep and many people go to the pharmacist before the GP or anybody else and so we have an ongoing program of that as well.

In terms of the aging brain, Brain and Mind Centre and University of Sydney and Woolcock we have intervention programs for interventions with Parkinson's, healthy brain aging because we know it's particular in our Parkinson's patients sleep is greatly compromised but also mood is as well. So overall we need to value sleep, set aside time to sleep yet achieve a realistic balance with our family's work and use the night time to let go of the day, not to worry, not to plan or connect with others through our phones and that's a big ask. But we are very adaptable and we can do this with good information and a lot of support. So thank you for this opportunity.

MS ABRAMSON: Thank you very much. I'm interested in where you spoke about what could be done in the perinatal phase and the type of training and support. So just interested in a bit more detail about that.

DR BARTLETT: Well, I think most ante or prenatal clinics there's very little information about sleep. There's almost no information about sleep post-delivery and a lot of people do not understand that babies are very active and very noisy when they're in active sleep, if they're still asleep and they do not need to be picked up so if you're continually picking up a baby when it's having active sleep then you're disrupting the sleep patterns and also disrupting calmness.

MS ABRAMSON: It's not my area of expertise so I may say something that you'll say, 'Oh no, that's not right' but we do have a lot of emphasis now on mothers attending sleep schools with babies but the intervention you're talking about is prior to a mother actually saying, 'I actually need some help settling the child'.

DR BARTLETT: Yes, so prevention is always a really good opportunity if we can possibly do it and sleep schools per se are often extremely expensive and a lot of the population are unable to access that.

MS ABRAMSON: Can I just ask you on an unrelated point; have you quantified the extent to which lack of sleep is contributed to depression, so do you have some sort of statistical analysis around that?

DR BARTLETT: In terms of postnatal depression it's probably about 15 per cent of the population and probably as high as 35. What we know in terms of the actual percentages in general population insomnia, it's quite (indistinct words) depend on the population that we're looking at but it can be, you know, 12 per cent (indistinct).

MS ABRAMSON: Thank you.

PROF WHITEFORD: So just on that, has there been similar work for depression other than postnatal depression or perinatal depression?

DR BARTLETT: A considerable amount of work between sleep and depression, so in some interventions where they've just looked at individuals who have both insomnia and depression and they just treated the depression, the insomnia stayed the same and the depression came back again. When they've looked at both insomnia and depression together they've had much better results and it's now suggested that you work with the insomnia first and then the depression in terms of interventions.

PROF WHITEFORD: Right, because they often go together - - -

DR BARTLETT: They do go together.

PROF WHITEFORD: And I guess the traditional way of looking at insomnia is that it's a symptom of the depression but what we've heard in this inquiry and what you're saying is that it's bidirectional.

DR BARTLETT: It's bidirectional, yes.

PROF WHITEFORD: Yes, okay.

DR BARTLETT: But it's interesting if you've only treated depression then the depression comes back whereas if you treat the insomnia and the depression you have much better outcomes.

PROF WHITEFORD: Okay.

MS ABRAMSON: Thank you very much.

DR BARTLETT: Thank you.

MS ABRAMSON: Could I please call Ms Chalmers. And if you'd be kind enough to say who you are and where you're from and also invite you to make an opening statement if you wish to do so.

MS CHALMERS: Thank you. Thanks for having me today and thanks for all your attention and time that you're taking to consider the speakers. My name is Lisa Chalmers. I am here representing School Nurses Australia. I'm currently employed as a school nurse at a large co-ed school in Sydney. I believe school nurses are one of the keys to addressing the issues raised today particularly by Jack van Bilsen at the wellbeing in schools presentation earlier today and I think it's a lovely (indistinct) from this speaker just before talking about sleep because I certainly know that Chris Seton, who is one of the experts in sleep in Sydney, says that (indistinct words) symptoms of depression that adolescents exhibit could be deal with by getting them good sleep, hygiene habits, so I think that's really important, thank you.

I would like to propose the role of school nurses as a significant cost effective primary health care measure in addressing the mental health concerns of our young people and their families in Australia. If we are able to identify these students and their families before they fall of a cliff, so to speak, the outcomes for our society as a whole would be remarkable. School nurses are in a unique position for the early detection and implementation of support for those students who are suspected to have poor or deteriorating mental health. Additionally, the role of a school nurse provides strategies in relation to good mental health and sleep hygiene which impacts mental health significantly in young people.

Often students present with somatic symptoms that are the first indications of mental illness to the school nurse so we're seeing them on the frontline. A thorough mental health assessment is always part of a school nurse's assessment. School nurses provide referral to appropriate services, school nurses work collaboratively with school counsellors, teachers and pastoral carers and we liaise with parents and guardians as is appropriate.

Looking at models of care throughout the world we see that most Scandinavian countries, the UK and the US all have well embedded school nurses integrated into their schools. I am very fortunate to be the manager of a health centre at a large private school in Sydney. I have an incredibly forward thinking very supportive principal and executive team and I see firsthand every single week the value of my role for the students at our school. At the same time my heart breaks for what this could mean for schools in less fortunate areas than my own.

What does this role look like in my school? Assessment and flagging of students and staff at risk or showing signs of deteriorating mental health, early referral of these students to appropriate services and supports. Our health centre is a safe place for timeout for those students that need an extra support during a school day. We participate in the student's support teams which is a weekly meeting between the school nurse, the counsellors, the heads of the school, the pastoral team, to identify any students at risk or concerning behaviour and develop an action plan early. Self-harm management in the everyday is dressings and ensuring that there's a safe plan for these students.

Just I guess a snapshot of the last week in my work life and this is just the mental health that I can just quickly think back on. I've managed several anxiety attacks, I've had one threat of suicide where an ambulance was called, I've had several self-harm presentations where I undertook physical dressings of their wounds and checked that their support systems were in place. I participated in a meeting to address a school refusal anxiety concern for one of our Year 11 girls and her family. I administered psychiatric medications to several students throughout the school on a daily basis. I managed an epileptic seizure which consequently

unravelling into a family situation of domestic violence and alcohol abuse. And I provided ongoing support for the boarding community which includes several Aboriginal Torres Strait Islander students on scholarships who (indistinct words).

And this is all at a privileged private school in Sydney so there's never a dull day but it also highlights to me just how needy these sorts of roles are. My proposal is funding for school nurses in every school in Australia as a cost effective frontline measure to address mental health concerns in school age children. And I'd like to finish with a quote from NASN which is the National Association of School Nurses in the US who are far ahead of us in Australia at having these roles. School nurses serve a vital role in the school community by promoting positive mental health outcomes in students through school community evidence based programs and curriculum.

As members of interdisciplinary teams school nurses collaborate with school personnel, community health care professionals, students and families in the assessment, identification, intervention, referral and follow-up of children in need of mental health services. In addition school nurses serve as advocates, facilitators and counsellors of mental health services both within the school community and the inner community. School nurses also offer themselves as a resource to learn and strategise with staff to prevent bullying and promote a safe learning environment in the student body.

School nurses are uniquely positioned between policymakers and the student body as caregivers, advocates and experts. This vantage point affords the school nurse the ability to identify and intervene with at risk adolescents as well as lead in developing a prevention policy. Mental health is a key component in children's health and development. Children need to be healthy in order to grow, learn and lead productive lives.

MS ABRAMSON: Thank you, Ms Chalmers. I've got two questions I wanted to ask you. First of all, we received evidence at the Commission that, and we put it in our report, trying to get access to child and adolescent psychiatrists is incredibly difficult so I'm thinking about your ability to link the student with services outside of the school environment and what your experience of that has been?

MS CHALMERS: Yes, it is very difficult and there are long waiting lists and we utilise a number of pathways I guess for our students depending on their situation. Some of it is actually seeing them to the emergency department, using private counsellors and psychologists and psychiatrists and also we're fortunate to have school counsellors at our school so they also work together with the students and the families but it is very hard to find good appropriate supports, yes.

MS ABRAMSON: Can I also ask you to - they're related questions. One of the issues is around stigma. Now, I'm going to make an assumption and you can correct me if I'm wrong but I'm assuming because you're the school nurse no one would know why a student had gone to see you so that would be part of why you can provide that support?

MS CHALMERS: Yes, absolutely and we often find that the students will come to us before they'll seek other services and that's why it is so critical for us to do a really good assessment of the whole student when we're just seeing them for a sore throat or a headache, yes, because

often (indistinct words) asking something else.

MS ABRAMSON: Can I also ask you about your ability to train in mental health. Have you done like additional qualifications or something to help you with that process?

MS CHALMERS: Yes, I have a Master's in public health but I also - I've done the mental health first aid training course. So that's - and, as a nurse, we have a whole component of mental health training in our undergraduate as well. So, I mean, I think, actually, school nurses probably need to have more. But, we do have a fairly solid starting point, yes.

MS ABRAMSON: And how do you relate to other wellbeing teachers? I think you said before that you actually have a process on a weekly basis where you meet?

MS CHALMERS: Yes, we do. So it's - we have a meeting to address students of concern that sort of get flagged from all over the school. And we sit down as a team and talk about those students and how best to manage them. Yes, so we have the counselling teams, the nurse and we have the pastoral carers and the heads of the departments if need be.

MS ABRAMSON: One final question - I'm sorry Harvey - how do you manage that difficult issue of consent with adolescents? Because we've heard this morning some very compelling evidence about parents who have wanted to be involved in treatment and couldn't be and guardians who weren't able to support the person the way they'd like. How do you go about that issue with people who are under 16 - and strictly speaking, by the law, probably need parental consent - how do you manage that?

MS CHALMERS: It is very tricky. And we walk a tightrope. And - where do I - it's - I guess it's a case by case basis, really. And we work collaboratively to try and work out what's the safest for the students, because for every caring family and parents that we've seen this morning, we - I mean, we have a 16 year old girl who has been prescribed medication for her depression and her parents have refused to allow her to take that medication. So, we have two sides. So, it's difficult.

MS ABRAMSON: All right, thank you.

MS CHALMERS: I wish I had the answer.

MS ABRAMSON: No, no, that is helpful. Thank you.

MS CHALMERS: Yes.

MS ABRAMSON: Harvey?

PROF WHITEFORD: So, just on the lack of access to child psychiatrists - I guess one of the issues for us is the connection between the mental health services provider that are in school versus those (indistinct) community. And I'm sure that varies depending on the community. But, have you got an established network of health professionals in the community that you can refer to, or that you can seek extra support or clinical?

MS CHALMERS: Yes, we do, absolutely. And certainly with - I mean we, our whole aim is to capture these kids at the beginning and try and nip things early. But certainly as their mental health deteriorates then progresses we absolutely use outside services and we have - essentially - we have a list of referrals and we absolutely involve the families, the parents and encourage that it's a family - and often, yes, it's looking after the family. It's having - a healthy family equals a healthy child too, sometimes. Sometimes not. But, we try to make sure that it is very collaborative, yes.

PROF WHITEFORD: Last question then would be - is there a support network for school nurses? By the sound of that the - what I would call - the case mix of work you've got. It's a full spectrum of physical and mental health issues that you could come across.

MS CHALMERS: Yes, absolutely.

PROF WHITEFORD: And, from what you said, perhaps, you know, asking one nurse in a school to cover that is asking too much often. But, do you have your own - or is there a structure or a support for you? Given you're the nurse in the school and you're not working in a hospital or a healthcare setting where there's senior nurses around. How do you manage that?

MS CHALMERS: Yes, well it is very much. I know a lot of - I'm fortunate I have other nurses that I work with. But it's a very isolating role. So, there's the School Nurse's Australia Association, and then each state has their own associations as well. And we endeavour - I'm the president of the School Nurse's Australia - and we endeavour to - part of that role is to really support school nurses in Australia. We have a two day conference annually where we get speakers in to education and upskill the nurses, along with lots of, sort of, social debriefing events, really, to collaborate and share experiences, yes.

PROF WHITEFORD: Right. But there is no - from what you said before, a lot of the support you get is within the school, where you have regular meetings with other senior staff in the school.

MS CHALMERS: Yes.

PROF WHITEFORD: But, professional nursing supervision wouldn't be routine.

MS CHALMERS: No, absolutely not. And I think that's - one of the goals is to develop a recognised pathway, like they have in the UK, for a school nurse. So, in Australia we have, say, a midwife program. Well, you'd have a school nurse program where nurses get specifically trained to be school nurses. And that, obviously, we'd incorporate a significant mental training component. Yes, so that's on our wish list of goals, yes.

PROF WHITEFORD: Thank you.

MS ABRAMSON: Ms Chalmers, we encourage you strongly to put in a submission.

MS CHALMERS: Certainly.

MS ABRAMSON: That would very helpful for the Commission.

MS CHALMERS: Yes, I would be very happy to.

MS ABRAMSON: Thank you.

MS CHALMERS: Thank you for your time.

MS ABRAMSON: Could I please call Orygen Professor - I'm going to pronounce your name wrong, I'm sure - Professor Killackey? Thank you. And if you would be kind enough to announce your name and organisation for the transcript, and I also invite you, should you wish to do so, to make an opening statement.

PROF KILLACKEY: My name is Eoin Killackey and I'm from Orygen. Thank you for having me - and, I guess, Orygen - here today. And thank you for the draft report that we've been able to read and comment on. Over 30 years now Orygen's been developing, researching and translating holistic and evidence based early intervention to transform the lives of young people and their families and to deliver significant social and economic benefits to the Australian Community. For that reason, we are particularly welcoming of the draft report's prioritisation of prevention and early intervention. As we were with the Commission's acknowledgment of the role of underinvestment in early intervention and prevention contributing to the poor outcomes currently seen in mental health in Australia.

We're in also in the agreement with the report's focus on holistic approaches that extended to other domains, such as education, employment, housing and justice. We are concerned, however, with the recommendation in the draft report to remove the protection of funding for headspace services and the headspace Early Psychosis program. We understand the headspace office has communicated with the Commission in relation to headspace. So, I'm here today to talk specifically about the headspace Early Psychosis program.

I thought I might start by giving a bit of a history of the development of that program. Because I think it's an important context. So, in 1992 the Early Psychosis Prevention and Intervention Centre was started in Melbourne and this was the world's first (indistinct) trying to create a model for intervening early in the treatment of psychosis. Up until then, people with schizophrenia often received late treatment and quite often before that, it was inpatient asylum based treatment. In 1996, the (indistinct) was founded, which was the first clinic to try to provide identification and treatment of people at risk of developing psychosis. And as these clinics were developed, research went hand in hand with that to understand how we could do this in an evidence based way and to make sure that what we were doing is effective for people.

The research had spread sufficiently that by the early 2000s the UK government invested, I think, at the equivalent of around about \$2 billion Australian dollars at that time to open up 150 early intervention services across England through the NHS. So, even though we developed this, by the time it came here nearly a decade after that, we were already playing catch up to the rest of the world. In 2007, as you know, headspace started and headspace was a primary care platform. It wasn't intended, necessarily, to be a place for the treatment of severe illnesses.

In 2010 I was lucky enough to lead a project for the National Advisory Council on Mental Health, where we looked into the feasibility of establishing an early psychosis model for

Australia. And we did this by conducting a large literature review of the evidence to that point. And also conducting consultations with international and Australian experts, young people with psychosis and their families and other people. That report went to the National Advisory Council on Mental Health, and a couple of years later in the 2012 budget there was funding for - what's become - the headspace Early Psychosis program.

The initial intent of that program - in our report we had set the (indistinct) to be 20 of these places across the country, with the idea that you get population coverage. One service, we're looking at around about a million people each. There was also acknowledged in that 2010 NACMH report that we didn't really know how to translate this model into less population dense areas. And that there would need to be consideration of how to do that. Although, I was re-reading that report in preparation for this, and there's a comment from a manager of a rural early psychosis service back then who said it's really important that we get the full model too. You could actually put an early psychosis on a service in the country, but it wouldn't be a - we need to figure out how to overcome the problems so that the people in the country get access to the evidence based model as well.

When the funding came in the budget it was meant to be a partnership between the federal government and the states, with around about 16 services set up across the country. And I think one of the threats with removing the protection of funding for a PHN is seen in that episode because over the next year and a half, agreement couldn't be reached between the federal government and the states to implement the model faithfully. They'd want to include bits and pieces of it, but not the entire model.

And then leading up the 2013 election, Mark Butler, who was the Minister at the time, decided that there would be nine sites and that headspace could have carriage of implementing this program and would be directly funded from the federal government. The important thing about that issue with the states is that this modelling is not modular. You can't just pick bits and pieces of it. It actually requires all of its elements to achieve the desired outcomes. So in 2014 some services were commissioned. In 2015 we produced a fidelity measuring tool for these services and that was quite useful to them across the ensuing years, because having regular measures of fidelity both allowed them to identify they were doing well but, in particular, it identified the areas where they had performed less well.

And I think, again, it's another threat - if we don't protect the funding around this - because the areas where they were doing less well are what you might call the non-clinical core bits of it. So, things like youth partnership and family engagement and support in the model of community (indistinct) and education. Reaching out for those other bits.

PROF WHITEFORD: So, Eoin, keep going through, but as you go through, do what just can do there for us - give us examples of how that fits with the recommendations for what we're doing here.

PROF KILLACKEY: That's all right. I'll probably get to that part. But, I guess, our greater concern about that recommendation of taking away the protection of funding - and this is probably irrelevant of which commissioning kind of model you go with - whether the renovate or the rebuild kind of model - if the money for this model - for the EPPIC - Australian Early Psychosis Model - isn't protected, I guess what we're concerned about there will be whittling

away of the bits of it. There will be less effective interventions provided for people. There's a real threat that the different elements which are now contained in one place and one service for young people and their families, will be contracted out to different providers. Which then creates gaps - geographic gaps - that young people and their families have to negotiate, which they don't currently have to do.

And I guess the other thing that we're sort of worried about is that there's a significant amount of evidence built up now over the last 30 years about the better outcomes that are achieved through this model, and the better economic outcomes that are achieved. And I guess we're concerned that some of that evidence hasn't been considered in the recommendation to de-protect the funding that surrounds that model.

PROF WHITEFORD: So, just, is the - correct me if I'm wrong - the argument is that the outcomes are dependent upon the fidelity adherence to the core model.

PROF KILLACKEY: Yes. To the model, yes. And I think, you know, one the things you could say in terms of the translation of just about every psycho-social intervention, is, you know, there's research evidence for everything. One of the things that we find as things get moved into regular practices - a drop off in the benefit that we see. And a significant part of that is because we don't control for quality of the intervention. If you think about it with medication, every tablet that is produced has got to the, you know, the milligram. The exact same constituent elements. We can't do that with psycho-social interventions. So we need to look to other ways of maintaining fidelity and, obviously, having a fidelity measure like we do for this, is one of those ways of them providing regular feedback to the services, so that they can actually adjust and develop in the areas that they need to.

PROF WHITEFORD: So, within a - however we construct the integrated community mental health service system that we're talking about - the challenge is moving away from the silos which are criticised, in (indistinct). And yet, in the service component, maintain the right quantity and mass and activity base that's essential for the outcomes that we've funded that service for in the first place. I guess that's the challenge.

PROF KILLACKEY: (Indistinct).

PROF WHITEFORD: Yes, and, so, how do we do that?

PROF KILLACKEY: Well, look, I think one of the reasons why we probably went down the track of early psychosis first, as opposed to, you know, other sort of things, is because there is just so much evidence for what to do in that space. Probably more evidence than there is any other area of youth mental health, definitely, and beyond that it's getting a little bit outside of my expertise. But, the idea would be that as develop evidence for the effectiveness of a similar service model for other presentations that would actually build on the system, (indistinct) to be, you know, early psychosis over here and depression over here, that, eventually, this would actually be joined up.

But at the moment, the evidence isn't there for what we do in these other spaces in quite the same way that it is for psychosis.

PROF WHITEFORD: So, just staying with that for a minute. So, currently, what connections exist between the early psychosis services and other components of the health and mental health services?

PROF KILLACKEY: So, in terms of the existing headspace Early Psychosis services, they've all got connections to state funded inpatient units, because that's not a component that they're funded to provide. Some of them, I believe, have got funding to sort of step up, step down, kind of care. They also - you know, different (indistinct) costed for six different (indistinct) have got connections to other relevant, kind of, community organisations that are useful for the services that need to be provided. I'd say though that one of the things that's probably strong about this model - apart from the flies - one of the things that is strong about this model is about its integration of many of those elements that people would have to go elsewhere to find before.

So, for example, in the function and recovery domain of this model, individual placement support is the, sort of, mandated intervention for helping people get to school and work. And I know that in other elements of the draft report, individual placement support has been recommended as an intervention that should be made available through all community mental health centres. This is already happening in the early psychosis programs.

MS ABRAMSON: Can I ask a bit about - or two non-related areas - but the commissioning. Given your strong support for the program, why would it not be the case in a commissioning model that all of the regional commissioning authorities would actually commission the psychosis support?

PROF KILLACKEY: We think there's a varying level of knowledge across the landscape. And, so, you know, some of the PHNs who are currently responsible for commissioning, completely get mental health and probably do a really great job around this. The problem is that some of them don't - and I think we've probably seen this a little bit with the roll out of the (indistinct 2.18.28) funding, where some of it's been targeted and probably quite well spent. And in other places, there's been perhaps a lack of understanding about what needs to be commissioned. And perhaps that's because the model's not quite so clear at the (indistinct). But, also, I think, one of the, kind of, other problems in mental health is that there is a tendency sometimes to put things into set ups which are well-meaning, but not particularly evidence based and which have got very little evaluation of the outcomes associated with them.

I think that's one of the fears that we would have if PHNs or other commissioning bodies were given absolute free reign about this. The other thing that we think might be a bit of a risk around this area is that if instead of protecting the money, and looking to expand to the original idea of getting population coverage, if the money within that measure at the moment wasn't protected, it could actually be diluted and spread out across a whole range of other presentations. And if you didn't have any resources into, then you're just going to provide a very thin service to people, and probably not be able to perform the elements that are currently part of that model.

MS ABRAMSON: Can I go back to the point that you made about education and will people - the PHNs may not know that much about that space. But your brand is very recognisable. That's one of the things that you've submitted very strongly to us. So, why would it be that

your brand would not be something that all of the PHNs would be thinking about the services that you provide? Or, in this case, the RPAs.

PROF KILLACKEY: Orygen's brand or headspace's brand, sorry?

MS ABRAMSON: The headspace brand.

PROF KILLACKEY: All right. Just to clarify, I'm not from headspace, so I probably can't speak so much about their brand.

MS ABRAMSON: Well, your brand.

PROF KILLACKEY: My brand, Orygen.

MS ABRAMSON: Yes.

PROF KILLACKEY: Look, I think if the brand - whether it's headspace or Orygen - was equally strong back when the measure was first budgeted for, and I think the evidence at that time was that, despite the strong brand and despite the strong evidence, there were varying levels of intent to actually implement the model faithfully. And I, you know, I guess our great fear is we've seen that happen then, with fear that it might happen again. And I guess what we've also seen is that in other places - so in the UK there was a bit of a drift away from the requirements of the early intervention of the early intervention services. And what that led to was a closure of a number of those services.

It was only when they introduced the fidelity measurement, and they also introduced some legislation around, you know, the parity of esteem between physical and mental health in the UK, that there was a revival of those services there. So, in other places where there hasn't been that requirement to protect that investment around this stuff, we've definitely seen drifts. So, there's a number of historical reasons and incidents in other jurisdictions, which I guess make us concerned that this would happen again.

MS ABRAMSON: I should apologise. I'm not asking you to speak for other people.

PROF KILLACKEY: No, that's all right.

MS ABRAMSON: Could I ask you though about your individual placement support work that you do. We're very interested in that, as you would have seen from the draft report.

PROF KILLACKEY: What would you like to know? That's actually been the bulk of my last 15 years of work, so I could be here for a while.

MS ABRAMSON: I understand that. Well, let me be much more targeted. We're very interested in it because it does seem to have very good outcomes for the participants. There has been some evidence that it was mainly use - and I may have got this wrong, so I apologise - with people with psychosis. So, it was a narrower cohort. So, given that the Commission is very interested in this, but it's quite an expensive measure, I'm just interested in what type of

conditions - if that's the right word - you would think it would be very efficacious for. And, also, how would we roll it out. That's the other issue.

PROF KILLACKEY: I'm so glad you've asked me these questions. Okay, well the first thing I would say is that, yes, particularly in Australia the research that has been done has been done with psychosis. And I guess that that merit is a lot of the early research in IPS internationally which has been done originally, I think, with chronic schizophrenia and other quite severe presentations. We translated it into youth mental health, where we have the educational outcomes as a component. And, as you said, in the two studies that I led we got nearly 90 per cent of young people with psychosis back to school or work. And we know that over a 12 month period 80 per cent of those people stayed vocationally connected.

Not necessarily what we got them into, but that's not what - you don't want to put people into something permanently - you want them to actually to actually go and do it themselves. So that's great. There's increasing research now looking at the application of IPS to other groups. So, we're running a trial looking at its application in young people with Borderline Personality Disorder. There's a number of trials in the States which are looking at its application in - particularly to veterans - and in people leaving forensic settings. There's obviously the DSS funded trial in headspace, where it's basically getting into the regular community.

The fundamental principles of IPS should actually apply everywhere. So long as you set it up in a situation where there's a care system around it. So, if you can imagine Veterans Affairs in the US, there's a care system around that and it's integrated with the rest of their care, which is the (indistinct). Same with people coming out of forensic settings, it's integrated with the rest of the, sort of, the support that they have as they move back into the community.

How would you implement it? I think there's a number of issues. So, the biggest first issue - and I think we're beginning to find this now with the DSS trial - is purely one around workforce. So we need a training mechanism - because it's not as simple as taking people who have worked and say job support or (indistinct) and (indistinct) there, because there's actually a cultural component you've actually got to get, and a, kind of, a buy into the idea that this is a client led integrated with treatment approach. It's not, sort of, about just getting the people their outcomes so that you can tick a box. And the other thing we've probably done a lot more with in the (indistinct), taking much more career-focused things. So blending education and employment outcomes.

MS ABRAMSON: Yes.

PROF KILLACKEY: So that there's some, you know, real long term benefit to this. I've been thinking a lot in the last little while about a, sort of, stepped care approach to this. Because, we've started to do some really interesting things using online support for training and employment support. And what I probably think is that there are a proportion of people - particularly, let's say, people coming through headspace - and even some people coming into, sort of, more severe settings where, I mean, it's psychosis or whatever they might be presenting with - who can get the level of support that they need from that sort of moderated online, kind of, platform. And I think that we should be doing a thing where we give, sort of, everybody a trial of that sort of (indistinct), that people who don't succeed with that move on to a greater level of employment support.

And one of the things that came out of the last trial that we sort of did is a suggestion that you can upskill clinicians quite significantly. So that - and I think part of it's an upskilling thing, part of that's a changing of mindset so that they actually begin to believe that vocational outcomes are possible for their clients. And they can transmit that belief to clients themselves. Because I think there's a certain amount of self-stigma which gets in the way of people's vocational recovery.

And then the highest level I'd say then are these IPS workers, who are essentially specialists within this system and who work with the people for whom those other levels of support haven't worked. I guess the only other sort of thing I'd sort of say in your recommendations around that, was a question about at what level should this be funded. My preference would be that it remains funded at a federal level and money transferred to - whether it's the commissioning bodies or whatever. So that the governance of the IPS work and the rest of the clinical programs is a single governance. But the, you know, the area of government that's got the most skin in the game of vocational stuff are the people who pay welfare payments. And, I think, that's probably the appropriate level of government to be funding this.

MS ABRAMSON: Although the other side of that, I guess, is the stakes are heavily involved in vocational education. So, it was - when we looked at it in the draft report, it's kind of a difficult question because both of the governments are heavily invested.

PROF KILLACKEY: Yes, it's difficult because it kind of fits in health and it kind of doesn't.

MS ABRAMSON: Yes. So, we made a choice, as you know. Really interested in what you said about the workforce. Because there's another part to it, of course. And, as you know, we've been concerned about workforce generally. And I'm sure you'll be making a further submission to us. So, on that particular Individual Placement Supports, any thoughts you have around what that workforce would look like? Whether we could draw on some peer workforce to provide some of that, would be very helpful.

PROF KILLACKEY: Yes. Well we've been - in one of our IPS set ups in some of headspaces in Melbourne have been using vocational peer support workers. And they work alongside the IPS worker.

MS ABRAMSON: Yes.

PROF KILLACKEY: And that's been absolutely fantastic for engagement of young people. You know, there's so much face validity when a young person is talking to another young person about the fact that this is actually possible, that you can manage your illness and work. It's been, I think, you know, I'm slightly biased. And we are evaluating it. So, hopefully, the outcomes will be as good as I think that they'll be. So, yes, there's all sorts of things. I guess, the other thing that we've been thinking about too on that front is having a, sort of, a much better career structure for people who work in these jobs. So that you might have some sort of fairly basic entry level, kind of, qualification to work in it.

But you actually could train up and become, you know, more senior in your roles, with more, you know, responsibility, but more trained up as well. Because, I think when you look at other

areas of employment support in Australia, there's quite a high churn of workers. And I think part of the problem that causes that is that there's actually not a career structure for people working in that business, so that, you know, they do it for a while and there's no greater challenge to move on to next, they go and do something else.

MS ABRAMSON: That's been incredibly helpful.

PROF KILLACKEY: Thank you.

MS ABRAMSON: Thank you very much.

PROF KILLACKEY: Thank you.

MS ABRAMSON: Could I please ask Ms Quilty from the New South Wales Council of Social Services. And if you would be kind enough to state your name and organisation for the record, and whether you'd like to make a short opening statement, thank you.

MS QUILTY: Thank you. My name's Joanna Quilty, I'm the CEO of the New South Wales Council of Social Service and I would like to make an opening statement.

So, thank you for the opportunity to appear before the commission and contribute to this very important enquiry into mental health. The New South Wales Council of Social Service is the peak body for the social and community services sector in New South Wales. We represent over 400 organisations who work with people and communities experiencing inequality and disadvantage. And our membership all too often sees the nexus between mental health and poverty and inequality in the community. They work with people every day who are missing out on support and opportunities because of what they can or can't afford, because of their cultural background, or because of where they live.

Our latest report, 'Mapping Economic Disadvantage in New South Wales,' which we've undertaken with the National Centre for Social and Economic Modelling, shows that in this state alone there are nearly 900,000 people who are living below the poverty line. And that rates of poverty are higher outside of Sydney in regional areas. This aligns with what we know about regional communities having poorer health outcomes. The sad reality is that social and economic disadvantage is very much associated with a range of adverse mental health outcomes. And this affects families and communities in every corner of Australia.

But too many Australians with a mental health issue are not able to access the appropriate supports when and where they need them. There's a significant missing middle of services for those in the community whose conditions are too complex for primary care, but who are not eligible for acute or specialist care. All too often we see that people's situations need to escalate to crisis level for them to be able to enter the system and receive any sort of care or attention. This places enormous stress on the individual, and their family and friends, as they become increasingly unwell. And for those who are able to access some kind of support, it is just so challenging to navigate the complex system - or, in fact, systems - that are involved that you almost need an army of support people to do so.

Enormous persistence, but in the end it can get down to sheer luck as to whether you get the support that you need at the right time. So, to put it simply, the system is broken. And it's not just the mental health system that we're talking about. The systems that are meant to support us all when times are tough fail us time and time again. The ongoing public hearings for the Senate enquiry into the adequacy of Newstart and related payments continue to demonstrate that people are not getting the right support to get back on their feet, and that the welfare system is fact entrenching them in disadvantage. And we think this is important to keep in mind when looking at how to improve mental health and wellbeing in the community.

NCOSS certainly urges the Productivity Commission to consider in its final report how the current income support system acts as a barrier to people meeting their basic needs, accessing care and opportunities, and how this impacts their mental health. NCOSS was very pleased to see the scope of this enquiry, including how sectors beyond health, such as social services and housing, can improve or impact mental health. We were also pleased to see strong recommendations in the draft report around improving mental health support in education and housing. The importance of providing and adequately funding a broad range of ancillary services outside the mental health system that keep people supported and connected in their communities can't be overstated.

This social architecture acts as a safety net for many who would otherwise fall through the gaps. And the social architecture includes locally based groups providing support, practical assistance, and a helping hand to those who have nowhere else to go. Services such as neighbourhood centres, tenants advice services, family support services, financial counsellors and community transport providers, who are critical to connecting people to healthcare, particularly in regional areas. We also need to recognise that the effectiveness of many of the Commission's draft recommendations is very much dependent on the health and community service sector's ability and resources to implement them.

Governments across Australia are increasingly transferring responsibility for service provision to the community sector, but without providing adequate indexation or growth funding. Services are seeing increased demand. And this is arising from a range of structural issues, such as lack of affordable housing, declining regional economies, slow wages growth. And yet services are expected to respond to this by stretching existing resources which are not sufficient to cover basic cost increases, let alone rising demand. Individualised funding models, such as those in the NDIS and aged care, are also increasing the complexity of the operating environment. Particularly, for small, locally based organisations.

And we're also seeing that such models are opening up gaps in the service system. As people are not able to access a care package, either because they don't qualify, the waiting time is considerable, or because they don't have the wherewithal to navigate the system. And, again, people are turning to local, more generalist community services, or to councils, because they have nowhere else to go. All these factors together present a real threat to community service's ability to respond and adapt to rising community need. This means that the social architecture that keeps people well, engaged in their communities and outside the formal mental health system is very much under pressure and at risk of crumbling, if it doesn't get some serious bolstering.

The Commission is doing vitally important work, and I urge them to consider these additional issues in the final report to address mental health in the community. We then need all levels of government to implement and appropriately resource the final recommendations. And this includes supporting the community sector adequately to continue to do its work. Too many Australians are being let down by a failing system and it is the responsibility of all levels of government to ensure it is fixed. Thank you.

MS ABRAMSON: Thank you, Ms Quilty. We have a few questions for you. I'm really interested in what you spoke about - community led initiatives and social infrastructure. And I'm thinking about how do we build some of those supports. Because it's not just about funding. So, I'm just interested in your views on that.

MS QUILTY: No, it isn't just about funding.

MS ABRAMSON: I know funding matters (indistinct).

MS QUILTY: Funding does matter. Or, at least, it doesn't have to be about additional funding. I think it very much about flexibility, about listening to communities, and about giving them control over how funding is spent. What is needed in their community and what might the solutions be. And I think we hear a lot about co-design and, you know, making sure that we are person-centred by working with the people on the ground with lived experience. But, I think how that plays out in reality is variable, and we're still probably very much at the learning stage. And I think that needs to be done - improved - significantly. I think we do need more regional planning structures and more opportunity for the different parts of government and the sector to come together and jointly plan for particular localities, given that localities are very different and their needs differ a lot. And, again, involving the community and listening to their voice is critical.

MS ABRAMSON: Thank you. One other thing I wanted to ask you was whether you had views about what we've said about mental health discharge. So, supports for people when, you know, we've said no discharge into homelessness. But, really interested in your views about how we can improve those services.

MS QUILTY: Absolutely. We are seeing increasingly people being exited from a mental health facility, or from prison, or from drug and alcohol rehabilitation and put into, often times, social or public housing but without adequate support around them, so that invariably they are – are greatly at risk of homelessness, and there just isn't that case coordination that's put in place, that's going to help those people get the support that they need. And I think it is a real gap. There used to be the Department of Community Services would provide that kind of case coordination for people that had complex needs, but as their focus has shifted more to children at risk of entering child protection and their resources are very much dedicated to that particular issue, it does seem that people that don't fit into their identified cohorts are missing out, and I think are really floundering in the system. Thank you.

PROF WHITEFORD: Thank you. So the question that I asked earlier; the issue of the psychosocial support network of services, which are – or, some parts are called nonclinical component of what's needed in the community is – you'll find, often, when we talk to different groups, they need different things by that term psychosocial support. Do you know of a – the

taxonomy that's used in, from your perspective, to describe the range of services which are provided by the agencies that, sort of, come under the umbrella that you provide, or you cover?

MS QUILTY: So, I guess the agents, or the organisations that are members of NCOSS are very diverse. They range in size from very small in, you know, quite rural and remote communities to bigger organisations that would have a head office in Sydney and multiple sites around the state, or even nationally, and they can be providing a whole variety of services from financial counselling, to family support, to domestic violence, to homelessness, to housing, neighbourhood centres, information and referral, disability advocacy organisations; our membership is very diverse.

I guess, when it comes to mental health, they're not necessarily mental health experts or specialists, but what they do is they have a role in building social inclusions, and that sense of connectedness and belonging. So they tend to be more generalist, I guess. A lot of them are, you know, whoever comes in off the street to a neighbourhood centre and is in need of some assistance or advice or support can usually either get it there or be referred to where they need to go. So it is about being accessible, it is about being locally based, and very much community focussed, and building up relationships with other local organisations, and just, you know, being part of that community.

So, very much for people that are socially isolated. I think a lot of the services provided by organisations who are members of NCOSS, they're very much about keeping those people connected, giving them a sense that they've got somewhere to turn to that, you know, they're not completely alone. So it is about, you know, helping – providing a bit of a safety net for those people, and we know there's more and more people in our communities that are at risk of social isolation and exclusion.

PROF WHITEFORD: So the funding that's provided to those organisations, is it generic social, you know, inclusion, generically defined, or is it for homelessness, for domestic violence, for - - -

MS QUILTY: It's very much targeted, and more and more it's about delivering very precise and clear outcomes. So, there's a move away from that more general, 'we're here to promote social inclusion, we're here to build community connectedness.'

PROF WHITEFORD: Right.

MS QUILTY: And more a focus on particular cohorts, you know, meeting targets and delivering outcomes. But I think they still, in amongst that, do as much as possible to be a part of the community and to build that connection and social inclusion, but it is becoming tougher, absolutely.

PROF WHITEFORD: Okay, thank you.

MS ABRAMSON: Just a related point, I guess, is that the Commission has had a lot to say about stigma, and I'm just wondering – I mean, we've suggested things like campaigns, et cetera, but just any views that you might have on how we can tackle the stigma would be really interesting.

MS QUILTY: Well, I think having those locally more universal services, who are able to be there for people experiencing isolation, or other, you know, anxiety or other mental health issues, they are non-stigmatising, because they are available for everyone. So, you know, whether it's a neighbourhood centre, a family support service, a play group; you can turn up, you can just be with other people who may be going through similar things, or who may not, and through building up trust and a relationship with others, then I think we can help to either provide necessary support or refer them to where they need to go. So I think it is a soft entry point, and it's non-stigmatising, and I think we need more of those.

MS ABRAMSON: Thank you. We welcome a submission, which I'm sure you'll make to us. Thank you very much.

MS QUILTY: Thank you for the opportunity.

PROF WHITEFORD: Thank you.

MS ABRAMSON: Could I ask – now, another one I will pronounce it wrongly, I'm sure, Carsten Schley, from headspace Sunshine.

MR SCHLEY: That was actually very good.

MS ABRAMSON: Thank you. If you'd be kind enough to announce your name and organisation for the transcript, and invite you to make an opening statement, should you wish to do so.

MR SCHLEY: Thank you, will do. So, yeah, for the record, my name is Carsten Schley. I'm the clinical services manager for headspace Sunshine. So this is a headspace centre in the western area of metro-Melbourne. I have been there for the last ten years, seven of those as the centre manager. So, thank you very much for the opportunity to speak. I had a really good day already, and I hope that I can dovetail a few things, but mainly, really, what I submitted to you today is already encapsulating a lot of the remarks that predecessors have made today.

My main hold, really, is for my contribution, perhaps, to keep helping from the Commission's understanding of the current strength and potential of the challenges of the headspace centre platform, and obviously with true authority, I can only speak for my own centre, having been in the business for a bit more, I think there are quite a number of centres that have very similar experiences to mine. It's a wonderful report, I must say. I strongly agree with most of the recommendations you're making. I do want to raise a concern, however, I have, with regard to what could be a potential misunderstanding of the current and future strength and limitations of the headspace centres. Specifically, I'd like to talk about outcome measurements, and like my predecessor, I would like to talk about the missing middle, and the importance of being involved in our families, and others, and if I still have time, also, peer support.

So the Commission correctly quotes the published evaluations of the headspace centres that say that on the basis of numerical changes on the Kessler 10, the K10 that headspace services achieved small improvements in the mental health of headspace clients. However, you also mention in the report that a clinical falls alone on outcome often overlooks, you know, the

many deterrents that, you know, can effect wellbeing and mental health, and so certainly would like to see that be broadened, perhaps, the view of outcomes beyond single psychometric measure, particularly when it comes to including the experiences of young people and family, and important others themselves, and indeed there are some publications available on what they have to say about their experience of coming to us.

So, I would say that, you know, before we can draw firm conclusions about the things that headspace centres really do achieve, we might have to, as you recommend, have a more comprehensive and nationally consisting monitoring and reporting framework, because I don't think that outcome is currently really captured adequately in the way that, you know, we are asked to measure it. Having said that, there are, actually, right now, in each headspace centre around the country of which there are no 110, a number of other outcome measures available that are actually self-reported by young people, and families that are perhaps far more eloquent, I suppose, in what they are experiencing of coming to us, then, as I said, the numerical change on the K10.

With regard to the missing middle, you've clearly stated that they headspace initiative was initially created to provide low intensity interventions for people with mild and moderate mental health problems, and you have also stated that low intensity interventions with people with early problems can be highly effective, and indeed we can see this at my centre and at many other centres in the country. And as such, I absolutely support your call for headspace centres to have an even greater focus on low intensity interventions, and I think we're doing really with that. However, if that is so, and if in fact the future funding of headspace centres should depend on, say, the amount of lower intensity services that we can provide, then you must include recommendations about where people can go when they need more than just invitation, low intensity intervention.

Just to illustrate what I mean, at my centre 60 per cent of the young folk that are now coming to us are now falling in the category of people with established and severe mental disorders, and there has been a real creep, and that's what you acknowledge with the missing middle over the years, from people who historically might have been, you know, presenting with early symptoms, but now, however, as I said, 60 per cent have ongoing severe problems, and the main reason that we are seeing them now is that our state system can't. So, people who have been turned away come to us, and because we have an open door policy, we see them, and we will make do, and with many we still achieve very reasonable outcomes, however most of our resources now are dedicated to looking after people who clearly demand a greater level of servicing than, say, someone who has just, you know, had a relationship break up, but otherwise they're okay.

So I absolutely, as a centre manager, would love to return to catching people, or problems, I suppose, early, and much earlier than we are currently able to do, and again I can't speak for any – every headspace centre in the country, but I do, you know, implore you to look at, you know, the variance of, you know, presentations that are coming to headspace centre, and clearly, if say for a centre like mine, and west of Melbourne, the ruling was that, you know, we would need to primarily support low intensity interventions and then to stay in government assistance need to be funded, accordingly, around so, so we can really, then, follow the staging model as you're proposing in the report.

Thirdly, I'd like to talk about the high importance of family inclusive practice, and we have heard some of that today, but a great deal. You, yourself, acknowledge that we do need to improve services to better meet the needs of families and carers, because we know, internationally, and nationally from research that outcomes are usually better if we do. Despite earlier recommendations and it's in the paper of (indistinct) that you offer, I have courted to increase the capacity of headspace centres to provide such family based treatments, actually no headspace centre in the country is currently providing any resourcing to do that kind of work.

What we do is that we are trying to partner, and in some ways are quite successful, with organisations in our community, and in fact that's one of the strength, I think, of the model, because we do have to partner, we do it quite well, but it isn't quite the same as having an integrated, you know, family peer support worker, for example, that is available, you know, most days of the week to provide the services to our family and friends that they really do need.

Just to give you an example, we have a complicated family peer support a half a day a fortnight, at the moment, at our centre, and as you can imagine, they are hopelessly overbooked. So again, I would just like to propose that you look at how can we boost, I suppose, the supports available to family and friends in our centres, you know, without necessarily having to rely on whether you can form partnerships in the community, because some area will not even have a child and youth and family service at their doorstep. They can provide that.

And then, maybe lastly, if I can, add that one as well, we have heard already throughout the day that obviously Australia is made up of many, many people from different ethnicities, and for languages, religious backgrounds, virtual beliefs and so on, and again there's a national platform for now 12 years we have been employed to work with people from non-English speaking backgrounds. My area, in Sunshine West and Melbourne has one of the highest (indistinct) densities in Victoria, and yet, I have absolutely no resource, at the moment, to help me speak the language of the people around us. So, as you will now, as a health provider, we have no national platform that currently funds translation and (indistinct) services our specialist doctors can, but that's obviously not enough when it comes to ongoing therapy.

And I can tell you, in the ten years that I've been at my centre now, there have only been two occasions where we have successfully managed to get an interpreter into the centre to provide ongoing therapy. We use it quite a bit of initial contact, but then, you know, we tell people about what headspace can do, in the language that they can understand, and then after that, you know, we basically lend them our bottoms, because actually there isn't a great deal more we can do. So again, just a recommendation, that if we want to be (indistinct) into the (indistinct) community, we need to be able to speak their language or understand them better. Thank you.

MS ABRAMSON: Thank you.

PROF WHITEFORD: Thank you for that, sir. What a good coverage of many things. I've got some questions that come out of that. So, what's the relationship between your centre and the National headspace Centre, and is that – is it working, is it not working, how could it be better? Especially, I suppose, with respect to, you know, data collection and those sorts of things.

MR SCHLEY: Yes. As you know, the relationship between headspace National Office and the centres has undergone various strains over – over the years. Based on the most recent model, what headspace National is now really involved in, apart from providing services on the, you know, the headspace schools, and the headspace Initiative, is to be helping us to – with workforce development, training needs, also with, of course, the standards that every centre has to work towards certain standards, how they do it however is up to the centre itself. So when we go through the accreditation process that we are obliged to do so they can operate under the brand, we don't just say, or have to say, 'Yes we do some community awareness work,' we actually have to spell out how we do this in the community. So headspace National Offices is very heavily involved in that, together with the PHN.

All our data is still going to headspace National Office, and they share a portion of that with the PHN. We as centres see quite a bit of (indistinct) back, but usually have the data that I can't drill into to really help me understand specific outcomes. So again, one can measure it's not ideal - - -

PROF WHITEFORD: Sorry, how? So dated back to back, your centre about the number of headspace centres?

MR SCHLEY: Well, I do have - - -

PROF WHITEFORD: For benchmarking.

MR SCHLEY: I do get the benchmark, against the national average, if you will, so I know that my centre, for example, sees twice the national average on complexity. But again, that doesn't tell me enough, you know? It doesn't tell me what's that about, and what kind of interventions would be more likely or less likely to help me address the issue. I do believe that there are ongoing challenges in figuring out these, sort of, three parents that we now have. You know, we have the PHN, we have the lead agency, and we have headspace National Office. I'm not sure that I know what the answer is to, you know, how that would work best - - -

PROF WHITEFORD: Walk through those three for me, again. Your PHN?

MR SCHLEY: Yes, as the funding body. And there is, you know, the lead agency. In my case, actually, it's Orygen, and then the lead agency has a consortium around them, so they might be five, six, ten, fifteen, however local services that have once put up their hand and say, we would like to be involved in the running of a headspace centre. And then of course there is headspace National Office (indistinct) brand, and originally were entrusted with some responsibility of setting up and establishing headspace centres. That now falls more to the consortium and the PHN, but headspace National still holds the brands, so they are still coming in with, you know, more fidelity. So it's quite a complex little number. It's a bit like Jim's Mowing. Jim can't mow all the lawns in Australia, so they have to contract that out - - -

MS ABRAMSON: I thought it was him.

MR SCHLEY: There you go. So I'm glad I can shed some more light on how complex that really is. For me on the ground, it actually leads, often, to a bit of confusion, you know, who I'm now going to report to or work with. I mean, I know for governance matters it's clearly

the agency, but they don't really pay me, so then I have to work with the PHN around, you know, outcome report, and work plans, and then I have to – to meet the model fidelity criteria for headspace National Office. So I'm basically drowning in admin, if you get me.

PROF WHITEFORD: So, would you be able to make some suggestions to us that would make it easier for you to operate where we didn't have that complexity. I think from what you're saying, and from what other people have told us, there's multiple attempts to try and integrate headspace into the primary, you know, mental health services and community mental health services for a region, but again maintain the identity and fidelity of the model, and the funding comes through a different channel to where your, you know, national body is, et cetera. So, it's trying to do too many things, perhaps? I don't know, but we'd appreciate some way of trying to simplify that.

MR SCHLEY: Yes. Actually, what I'd like to do, maybe, is to divorce the question around governance and funding and reporting from what actually a headspace centre does on the ground, because I think what gets often forgotten is the main strength of the model, because, you know, my centre is one of four that is governed by Orygen, and these are all within a 25 kilometre radius. Although they're all operating under the same brand, and therefore have to be compliant, if you will, with the fidelity criteria. Even those four centres are quite different, they are always geared towards what does the community want. And I am not saying that we are the be-and-end-all of that now, because I think their community development will be fantastic to have part of any kind of service, but we don't. We still, kind of, we're having no youth reference groups and family reference groups. And we do ask, but I think to truly engage in community and co-design, we would have to do, you know, things quite differently.

So I don't think it's the centres on the ground to actually, you know, uphold the really good at what, you know, they're doing in terms of partnering with organisations, and not doing them all themselves, even though we're meant to be a one stop shop. But it's not the intent of a headspace centre to do their own thing. Actually, the model says you know, you need to partner, you need to be establishing yourself in the community. Where it gets a bit mucky sometimes is then who determines that goes in the community. So I might have a great idea, but the PHN might have another, and this is where we start to get, you know, into a bit of trouble. And if you have, then, two other parents who also might chip in some ideas.

So, can I give you an idea by what is the governance model would look like? Probably not at the moment. I can do a bit of thinking, but on the ground I can't tell. I just want to, you know, get across that it's not so much the centres on the ground that are part of the issue here, rather than how and where they report to, who actually makes the call on what they're doing in the community. Because a lot of them are being told, 'You need to do what your community wants,' but then we get initiatives, you know, to our doorstep and we have to, sort of, roll out, we think, 'I'm not sure that that's really what we need.' But, you know, it would be good for one region, but not for another.

So this is always where I thought, if the model was brilliant, actually to say, 'You do what is important in your community, whilst upholding standards, the evidence-base, and whatever.' But that becomes more, I think, more of a threat now that they don't call.

PROF WHITEFORD: So, just to put – sorry, one more question around that, and it extends that area. So, for example, there's a lot of promotion going along for more low intensity services, or increase access to internet based therapies, et cetera. How does your headspace respond to that? Like, do you think, you know, we sat down and thought about how we might fit that in, whether it's applicable for us in our local community, or how do you handle those, sort of, I guess, suggestions about where on the Stepped Care Model we should be, you know, referring our clients, our consumers.

MR SCHLEY: Well, again, I can only speak for my own centre, and I must say that we perhaps have been way ahead of our time there, because we used to deliver low intensity and online interventions eight years ago. We struggle to do that now, because of the change in, you know, the young people and that profile that comes to us, now, who are no longer perhaps just responding to low intensity. But what I can say, with regard to low intensity: seven years ago, when we noticed that we had more and more young people coming in who deserved more significant intervention, or care, or needed more care, we actually established in our centre, a different pathway which became a student run clinic, or the brief interventions clinic, which is exactly those kind of low intensity interventions that you're referring to.

When people went in there, those people with early problems, within three to six sessions, they, themselves, reported a significant increase in mental wellbeing, functioning, and what have you. That is absolutely without doubt, when we should intervene, and when we also need the littlest investment to have the greatest outcome. These days, I'm spending most of my time scaffolding around people who probably don't do that well on the headspace platform, who do probably need – or not probably – they do need a tertiary wraparound, team based, case management and integrated care, which is very hard to replicate for headspace centres, and then we get, sort of, Band-Aids, you know, like Eoin was talking about, that could use severe funding.

You know, a single person in a 1,200 kids that we get a year, it's a drop in the hot stone. It does not replace, you know, an integrated, team based, you know, state mental health service, and I've worked for many of those in my career, and those services too, and they are better for certain people. They're a better fit than (indistinct). And again, we have seen such a decrease of what our state services can see, or shall I say, not keeping up with (indistinct) and integrated, you know, outcomes, and generally that now our centre, or our centres, I suppose, you know, choke on, you know, needing to deal with, I guess, you know, complex issues that probably weren't meant to be addressed in the first place.

PROF WHITEFORD: Okay, that's – okay.

MR SCHLEY: But online (indistinct) providing to our centres, and works really well.

MS ABRAMSON: I might unjust ask you one question, then we'll break for afternoon tea. Do you look at the outcomes of individual practitioners? Because we had some evidence on Melbourne about the monitoring of outcomes for individuals - - -

MR SCHLEY: Yes.

MS ABRAMSON: You do?

MR SCHLEY: I do, on the basis of the very limited outcome measures that I have. I much prefer final audits, because I don't miss the context, and the qualitative elements. If I just look at the (indistinct) then I think that's unfair to anybody, because, like, you know, with the brief in the lecture clinic works, we have clearly seen that once people might still have a high K10, they themselves all say functioning so much better, that's all I needed. So it's really, really vital that we ignore the review from just, you know, looking at psychometrics, and include, you know, the personal experience of people, because otherwise we will not measure change properly, I don't think.

MS ABRAMSON: Thank you. Thank you very much.

PROF WHITEFORD: Thank you very much.

MS ABRAMSON: We'll have a break now until 3.30. Thank you.

SHORT ADJOURNMENT

RESUMED

MS ABRAMSON: Thank you if we can reconvene the hearing. Excuse me, if we could reconvene the hearing. Thank you, and if I could please call Ms Pickett. If you would like to state your name and where you're from for the record and you might like to also make an opening statement.

MS PICKETT: Okay. So I'm Lynda Pickett. I'm the Australian Project Coordinator for Vicious Cycle PMDD. We're a global patient led project passionate about raising awareness of premenstrual dysphoric disorder and improving the standards of care for people living with this debilitating condition. Firstly, thank you for allowing me to address the commission and to represent the one in 20 women and individuals assigned female at birth of reproductive age who live with premenstrual dysphoric disorder. Historically we've been overlooked in conversations around mental health and we're grateful for this opportunity. We applaud the recommendations in the draft report, but we feel that unless there is a targeted action plan to address the complex needs of premenstrual dysphoric disorder patients, our community will continue to struggle.

Before I go any further I just wanted to address figure 1, which is who is mentally distressed and unwell.

MS ABRAMSON: In our draft report?

MS PICKETT: Yes. So we were surprised to see that it did not include differences in the experience of mental health between the sexes, male, female, non-binary and transgender in their experience of mental illness. We know that women are twice as likely as men to suffer from depression, three times as likely to be diagnosed with bipolar disorder, three times as

likely to attempt suicide during the reproductive years. It's also important to note that transgender men pre and post transition face additional challenges that influence symptoms of depression, anxiety, rage and suicidality as a result of hormone replacement therapy and/or continued ovarian cycles.

To oversight these gender disparities would be to ignore the impact of sex hormones on mental health and misrepresent those living with hormone based mood disorders such as myself. So premenstrual dysphoric disorder if you aren't aware is a cyclical hormone based mood disorder. It's a severe negative, cognitive and emotional response to normal hormone fluctuations. PMDD has been included in the diagnostic and statistical manual since the fifth edition in 2013. In 2017 the National Institute of Mental Health researchers discovered molecular mechanisms pointing to an abnormal cellular response to ovarian steroids as the root cause of PMDD, providing once and for all that the very marked irritability, depression, anxiety and dysfunction experienced by some women in the luteal phase was not just PMS or all in their heads and far from what some have argued in this country to be a social construct.

In May of this year the World Health Organisation added PMDD to the international statistical classification of diseases and related health problems in its eleventh revision, validating PMDD as a legitimate medical diagnosis worldwide. Despite this all - sorry, despite all of this PMDD is not currently part of any GP training. There are no training and development opportunities for GPs to upskill in this area. RACGP have no publications on PMDD. Australia does not currently have national treatment guidelines or an interdisciplinary consensus on the management of PMDD. When I questioned RANCP about why there were no detailed guidelines on PMDD in their document for mood disorders, I was told the document was already too long and in that moment my experience was reduced to a waste of paper.

So patients are now doing what they can with - from the bottom up, because we're not getting support from the top down in Australia. I'm privileged to have been given permission to share with you a few of the preliminary findings of the 2018 global survey of premenstrual disorders. This study was a collaboration between the international association of premenstrual disorders, Vicious Cycle and Me v PMDD, which is the world's first PMDD specific tracking app, and overseen by Dr Tory Eisenlohr-Moul, Assistant Professor of Psychiatry at the University of Illinois at Chicago, and IAPMD Clinical Advisory Board chair.

I must note that while complete findings are still pending scientific peer review and publication, preliminary data is available which reflects IAPMD's internal analyses. The full results will be published by the IAPMD Clinical Advisory Board in a peer review journal in 2019, as well as shared through a series of white papers. So these were our findings. In our sample of 1,425 patients with prospectively confirmed PMDD, 30 per cent reported that they had attempted suicide to escape their symptoms. In comparison the similar statistic for depression is 10 per cent. Patients are an average of 6.15 providers before receiving a diagnosis of a premenstrual disorder.

Patients waited an average of 12 years for an accurate diagnosis. The Australian specific statistic is eight years. 16.8 per cent reported having lost a job due to PMDD. 56.7 per cent reported having lost an intimate partner relationship due to PMDD. 98 per cent and 97 per cent feel PMDD puts a significant strain on their intimate partner relationship and family relationships respectively. 42.7 per cent reported problems with parenting due to PMDD, while

10.5 per cent felt completely unable to parent during PMDD. Early analyses of the study shows it is consistent with a history of studies, finding higher suicide attempt risk around the onset of menses, highlighting the need to take this issue seriously and conduct further research including experiments to understand how hormone changes contribute to this risk.

People living with PMDD have a number of additional challenges. We face misdiagnosis because our symptoms are so similar to bipolar disorder, rapid cycling bipolar, as well as generalised depression and anxiety. If at the GP level we're not asked to track our menstrual cycle against our moods, we're often misdiagnosed as those other disorders and then mistreated with inappropriate medications, and that hormonal element isn't taken into account and without that being treated the other treatments are ineffective and we just bounce around the system trialling medication after medication.

We're often dismissed at the GP level as simply having PMS. I would like to just have PMS. It's experienced by most people who menstruate. PMDD is specific to only 5 to 8 per cent of the population, and we're talking about a severity that renders them unable to work, study or maintain interpersonal relationships. We also face the taboo and the additional stigma that surrounds periods and talking about menstruation. There is currently no test, saliva, urine or blood test that can diagnose PMDD. So we are relying on doctors to ask for prospective symptom cycle tracking for at least two months. This is crucial to establish that essential hormone connection for correct diagnosis and treatment.

Then we have the fractured medical system between gynaecology and psychiatry and the lack of communication between the two. I've personally contacted all the big players myself, and they pass the buck. So RANZCOG points the finger at RACGP. RACGP points the responsibility back on RANZCOG, and I told you what the response was from the president of RANCP. The excuse is always given that more research is needed, but as I've outlined before the evidence is clear, the rest of the world is on board and it's time for Australia to step up.

We need a national action plan for PMDD, not dissimilar to one we've just seen executed for endometriosis. That up fills medical and mental health practitioners in diagnosis, treating and supporting PMDD patients, one which draws on advice from experts in the field. I will point out somebody who's doing exceptional work is Professor Jayashri Kulkarni from Monash, and Professor John Eden from the Women's Health Research Institute Australia as people to draw on as experts in the field.

It also needs to be one which utilises valuable patient consultation. At the moment, we are surviving in peer support groups online. That's all the support that we have. We have the IAPMD, who are doing exceptional work, and I urge anybody who wants to include premenstrual disorders in the work that they do in mental health to look at that website. There are resources for providers, for patients, for families. It's an excellent resource, we need to use it as a model for someone localised here in Australia.

Early intervention and education in communities and schools, and public awareness campaigns, along with support for patients, is sorely needed. But the good news is that all this can take place immediately within the current structure, and it has the potential to greatly improve mental health and social outcomes for the PMDD community. In the notes that I've submitted, I listed a whole range of ideas and - - -

MS ABRAMSON: We have those, thank you.

MS PICKETT: - - - and ways that I personally view, going forward, with an action plan for PMDD, if you'd like me to discuss any of those I can, but – yeah, I guess my main point here is that PMDD awareness is suicide prevention, and at the moment we are completely, just, being pushed under the bus.

MS ABRAMSON: Ms Pickett, thank you very much for coming to give evidence to us today. I don't imagine it's an easy thing to do, and you're speaking on behalf of a whole lot of people who wouldn't have a voice unless you came and spoke to us, so thank you for that. I'm going to ask my colleague, Professor Whiteford, to ask you some questions.

PROF WHITEFORD: So, thanks for taking us through that. It's obviously a challenge to, as you said, to try and capture an experience which has been hard for you personally, and certainly for people that you now know a lot of. We haven't, in the report as you rightly point out, gone into specific disorders in detail, and tried to provide a recommendation about, you know, clinical treatment, or services for specific disorders, and given that you can target specific disorders, as you said (indistinct) and endometriosis, but also require mainstream services to better accommodate disorders which are under recognised and under treated, you started to touch on how we might be able to get mainstream services to better recognise and provide support and treatment.

MS PICKETT: I think at that governing body level, once a new disorder comes into those documents, like the World Health Organisation listing, once new diagnoses arise, they need to become part of formal training. It doesn't matter if it's PMDD or something else. There needs to be a process where it becomes part of the curriculum.

UNIDENTIFIED SPEAKER: That's what I was saying.

PROF WHITEFORD: And from what you've learned so far, that is not happening with PMDD.

MS PICKETT: No, my doctor learned everything she knows about PMDD from me.

PROF WHITEFORD: And your doctor is a general practitioner?

MS PICKETT: Yes.

PROF WHITEFORD: And as far as Professor Kulkarni, you mentioned, who's a prominent Australia psychiatrist who's done a lot of research in the area, have you had a chance to speak to someone like her about what she believes could be done?

MS PICKETT: I believe she's working on a diagnostic tool. She's also on a women's mental health board, I believe. But I've just noticed in the way that she has been publically speaking about this, we did a television thing together, you know, just even starting the conversations. She's coming aboard, and she's speaking out, and the information that's she's giving is really

dispelling those myths, and the confusion between PMS and PMDD, and she's upskilling her colleagues, and I just commend her for that.

PROF WHITEFORD: So, do you take that as the start of a process, then, that needs to then continue and expand significantly, what she's doing?

MS PICKETT: Yeah. I don't know of any other professional doing what she's doing. Professor Eden has done some good work. But when I try to advocate for him to become more involved, it wasn't – it's not his area of speciality. He's a menopause guy. There's just no one to go to in Australia who's an authority on this.

PROF WHITEFORD: Okay.

MS PICKETT: I wrote to Ms (Indistinct) and asked for advice, and I was directed to Jean Hailes for women. I've given them feedback for years. They've made some small changes to their website, for example they've included a link to the IAMPD website, which is the one that I mentioned earlier; they've had a few articles in their magazine. But there's actually no practical support for us. I got them to link to the – the (indistinct) guidelines, which is what our GPs refer to, in the management of PMS. I've got them to link that to their website as well, but I just think there's so much more than can be done.

PROF WHITEFORD: All right. Thank you for that. I'm sure there is a lot more that can be done – but that, I think putting on the agenda here, is part of that process, I suppose.

MS ABRAMSON: And Ms Pickett, if I could encourage you – I'm sure you're doing all of this in a voluntary basis, but putting a submission into the Enquiry would mean that we have something in a form apart from the transcript that we can take into account.

MS PICKETT: Yes.

MS ABRAMSON: But thank you for coming forward.

MS PICKETT: No problem. Thank you.

MS ABRAMSON: Thank you. Could I please call, Jonathan Harms and Peta Smit-Colbran. And if you'd be kind enough to announce who you are, and where you're from, and make an opening statement if you wish to do so.

MR HARMS: Thanks. My name is Jonathan Harms, and I'm the CEO of Mental Health Carers NSW, which is the body recognised by the New South Wales health department for families and carers of people experiencing mental illness.

MS SMIT-COLBRAN: And my name is Peta Smit-Colbran, and I am a policy officer with Mental Health Carers NSW.

MR HARMS: And thank you very much for having us along today. Mental Health Carers NSW is very pleased with many of the recommendations of the draft product in the Commission report, including the suggestion to amend the test for carer payments, and relax

the hour test of on education for carers, to implement family-centred practice across the mental health system, and the carer experience survey, and have that data publically reported through the AIHW to allow practitioners to bill up to four family consultations through Medicare each year, and to correct the lack of data collection on mental health carers to inform decisions about carer services and funding.

However, we'd also like to highlight several issues of importance to carers in the sector, which could be broadly categorised under two headings, providing a safe, competent and effective mental health system, one that recognises the relational and bio-psycho-social model of mental health and recovery, and design services accordingly; and providing a system which recognises the unique and specific challenges experienced by families and carers, who provides and evaluates services that support their needs, to allow for their continuous improvement and expansion as required. On the detail of the specific carer support services, I'd like to go to Peta.

MS SMIT-COLBRAN: Yep, okay. So the Productivity Commission has rightly identified that although carer support services are valued, and are critical for family and carers, data collection on these services, and evaluation of these services is limited. I think that these should be addressed in the recommendations of the final report. For instance, you could add a recommendation that in the short term, while the ICSS is providing services for mental health services, data needs to be collected on the number of mental health carers who interact with the carer gateway, the number of mental health carers who receive services through the ICSS and the demographics, and the number of mental health carers who are eligible for the ICSS but are unable to access services.

MS ABRAMSON: Would you be kind enough to say what that acronym is for the purpose of the transcript.

MS SMIT-COLBRAN: It's the Integrated Carer Support Services. So that's the new services that will be delivered through the Commonwealth. Yes. And the number of mental health carers who are eligible for these services, but are unable to access them, if specialised services aren't available. In the medium term, government should agree on a set of outcome measurements for mental health carer services, which are publically reported through the AIHW. If the recommendation of the Productivity Commission to transfer mental health carer services to the state is agreed upon, then the arrangements which describe their responsibilities, should specifically mention data collection and evaluation of services. It's really important that this is included so that funding bodies actually have information to make decisions. At the moment, that's one of the specific reasons which is cited when decisions are made not to fund carer services.

So, I think the second item which we want to address is just recognising the relational aspects of mental health support and recovery, across all mental health services, and so do this we recommend a number of possible additional recommendations, such as expanding the mental health carer peer work force. This is really important, because carer peer workers can do what consumer care workers do for consumers in mental health, but for carers. There are very few specific carer peer work positions available, currently. Implementing definitive models for local health districts to implement family-centred practice, and mandating these. So, for instance, Mind Australia has published a practical guide for working with carers for people

with a mental illness, and in addition we acknowledge the recommendation that staff be hired who are dedicated to family with children in local health districts, but we think that this recommendation could be further to out additional staff who are just dedicated to working with family and carers this works well in the New South Wales context, with the family and mental health carer program that has driven quality improvement initiatives throughout the system, specifically related to family and carer engagement.

MR HARMS: Yes. It is very important, given the impact of those caring relationships on mental health and recovery, that we develop and support the caring environment that the person lives in from day to day, including addressing any obstacles that that environment might be creating to the recovery of their loved one, through ignorance of bad practice, just because they have never specifically been trained in being a mental health carer, as most people haven't.

That brings me to building a safe and competent mental health system. We are continuing to consider and refine the very detailed report that has been produced by the Productivity Commission and we're becoming more supportive of a number of aspects of the recommendations as we go on, but we still have some specific area that we'd like to see further developed.

MS ABRAMSON: Sure.

MR HARMS: So, with regards to the regional commissions centres that have been suggested, that would allow regional planning to take place between the relevant state and federal entities, for purchase of services on an ongoing basis. Regional commissions centres could be a way to achieve a consistent and collaborative approach in state and federal service planning, but we must take steps to prevent the perpetuation of silos between physical and mental health services. There are currently four projects being undertaken in New South Wales, at the moment, to address the physical health of people who experience mental illness, given the 20 year life expectancy gap between them and the general population, which is something which clearly needs to be taken very seriously.

We do fear that if all mental health services planning and commissioning is removed from the normal planning processes of health services, that that could create another barrier, but we're also aware of the fact that over – they calculate 50 per cent of Australians have a chronic health problem of one kind or another, and we don't support chronic health – physical health issues much more effectively than chronic mental health issues, and so if there should be a joint service plan of this kind between PHNs and state governments, or federal and state governments, then it should probably be rolled out to the chronic health and disability sector as well, and that would actually, probably, have a number of lateral benefits.

We say that new services must be co-designed with consumers and carers, if they're going to be effective. And importantly, the services must offer a range of options to fit highly individual and relational needs to support a person's recovery, because mental health is intensely personal. Instead of building specific steps for a Stepped Care Process, like stepping stones across a river of illness to the new country of recovery, there needs to be a causeway of stones which allow people to pick their own meandering way across. Because they will meander anyway, followed by their carers, and if the stones aren't there, they will simply fall in, instead of safely crossing to the far bank.

MS ABRAMSON: Don't be surprised if you see that in – but we give accreditation.

MR HARMS: Joint commissioning mechanisms could and should be contemplating by all kinds of chronic care, but I've addressed that previously, and new entities must ensure government commit to finding all the communities' needs, across the acuity continuum, rather than allowing (indistinct) to be perpetuated, or people to consistently fall out of care in an unplanned manner time and time again, with nothing being done to address the situation, in the comprehensive and competent fashion. The Productivity Commission should demand transparent reporting from governments, until (indistinct) has been decisively eliminated, and that brings me to the following point, around the information technology needs of the new scheme.

Information technology is required by responsible, responsive and competent mental health system. However, currently we do not have an IT system which would allow consumers to have one health plan which they develop, supported by their carers and clinical advisers, and which all service providers collaborating in delivering that care can see, understand their role in it, and also understand that multiple inputs are not going to create perverse or dangerous outcomes for the consumer, such as the mixing of medication, or the changing of medications, randomly, just because you've changed care settings, being admitted to hospital for example. That is intensely dangerous in the mental health system, and it is shocking that we don't have an information technology system that allows people to absolutely understand what is happening for a person in the community, when they're admitted through an ED to hospital.

Similarly, we do not have a system that would allow regional planners what all the different funded services and inputs government are putting forward and delivering in a particular region, in terms of the available services. This is vital, so that we can match what we are delivering up against the predictions of a national community mental health service planning framework, so that we can understand what should be provided, we can see what is effectively being provided by the state and federal, and to an extent local governments, and then we can match the delivered need or services against the need that is actually required by the community, and the just – the framework, the planning framework, as well as the funding for services to make sure that they are actually accessible by everybody who needs them.

Without that kind of model, which has been generated by a number of organisations, including the Sax Institute, and I believe that they even worked on the Mental Health Atlas have also done such modelling, then we are boxing in the dark and it is highly irresponsible not to be able to understand what changes you will achieve on the ground when you change different funded inputs. So there's an example used from western New South Wales where they wanted to implement two of the nine evidence based strategies to reduce suicide prevention, both of them would have stimulated demand for mental health services and so when they ran it through the model they found that that would increase suicidality because you hadn't already provided enhanced access to mental health services before you stimulated the demand.

So these are vital needs which a responsible system should fund and provide automatically to all public health service (indistinct). Mental health and other related support systems must recognise the role of relationships in supporting healthy development, the experience of mental wellbeing and recovery and support the role of carers in their loved one's life and treatment,

and the carer's own needs as individual citizens and potential clients of the same mental health system if they do not receive adequate mental health support. This of course includes carer breaks or carer respite, which must not be envisaged as a mere incident of support for consumers but should be a dedicated and co-designed support system specifically for mental health carers themselves, and we note that the funding that used to be provided to mental health carer respite has been in scope and allocated to the NDIS.

There is actually no clear way of consistently removing that funding and using it for carer benefit and so we would suggest that that whole system needs to be refunded for mental carers definitely, and probably for all the other carers as well. Thank you very much.

MS ABRAMSON: Thank you very much, that was a very eloquent presentation. I wanted to ask you a couple of issues which perhaps - and we've got the comments that you've made to us which we'll take on board.

MR HARMS: Thank you.

MS ABRAMSON: We had a really interesting and further participant's - quite a distressing story this morning about issues of consent, and that the people who gave evidence to us this morning really told us they were in a position that for an adult child they were unable to be involved in the care and their voice, to be honest, was actually neglected. The Commission is struggling with how to balance the rights of the individual, which for so long the sector has fought to have the consumer's voice heard, but we're trying to balance that with what could be done to give carer, genuine carer involvement, especially in circumstances where the person subject to the treatment is not in a position to give that consent. So I'm interested in your views.

MR HARMS: Well, look this is a problem that does arise quite frequently and it's not got a straight forward answer, but generally speaking the rules around confidentiality are important and it is important in respecting the autonomy and individuality of the consumer to respect their confidential information and not to give out holus-bolus to anyone who seems to be interested. However, just as carers can sometimes not be appropriate to be involved in someone's case because there's a history of abuse or some other issue like that, we can also say that consumers are not always totally committed to their own recovery or wellbeing when they are unwell.

And that creates a problem because if someone actually is determined not only not to look after themselves but maybe to actually actively harm themselves, it's important that information that allows the risk to be assessed and steps to be put in place to protect safety is available to the clinicians and the people that are going to act in that case. So we would - we've actually suggested to the New South Wales health department and we'd suggest again that a protocol around the sharing of information should be co-designed between clinicians, carers and consumers that clearly articulates that safety is the key and most important factor and that confidentiality should be observed as a rule but may be breached when safety is at issue.

And so we could develop a number of rules and mechanisms around how that could be done, but it should be done in a very open and transparent way with clearly articulated mechanisms and advice to all clinicians so it's done in the same way. New South Wales has had some very good success in a way with a designated and principal care providers - - -

MS ABRAMSON: Yes.

MR HARMS: - - - role recognised under the Mental Health Act which came on after the principal care provider, but even there we advocated for the creation of the principal care provider role which can be nominated by the treating team and not the consumer if they are unable or unwilling to do so, so that people who are providing care to someone in the community don't have that role ignored or destroyed because the consumer has said that they don't want any information to go to anyone under any circumstances when that is actually so that they can do things which are not consistent with their own safety.

MS ABRAMSON: We would be really interested in a written submission from you on that, it was - this morning it was really a very distressing circumstance that the people found themselves in so I would welcome that. Thank you.

MS SMIT-COLBRAN: I think just to add, often it's seen like as a conflict and I think it's a really common misconception that somehow family and carer engagement conflicts with the rights of the consumer to confidentiality et cetera, whereas in fact what we know is that many people when they're well state that they do want to have their family involved and even when people are unwell they will often want to have their family involved as supporters. Another point is that when we look at family engagement it's not about necessarily involving the family completely, it's about navigating ethically when - - -

MS ABRAMSON: Yes.

MS SMIT-COLBRAN: - - - to involve the family and how to respond to the family in a way that is supportive of what the consumer wants as well. So rather than look at it as something that contradicts itself, I think we should be looking at it as something that we do in tandem. Often when we exclude carers and family members, even when those carers and family members are problematic in the person's life it means that those issues go unaddressed. So it's far better to include them, to engage with them, to be supportive to them within the boundaries of confidentiality, and there are many ways for staff members to do that practically on the ground, and what we've found is that often practitioners lack education and understanding about how they can engage with family and carers productively, so they avoid doing that.

This has been noted through the Family and Carer Mental Health Program in New South Wales. So we have dedicated staff employed through the Family and Carer Mental Health Program within local health districts and those staff often engage with practitioners across the districts to improve their knowledge and to provide training around how they can be engaging with family and carers better and even they have found it to be the extent of knowledge around what people's responsibilities are under the Mental Health Act and under numerous policy directives which mention family and carer engagement. Often staff aren't aware of what those responsibilities look like and how they should be translated in practice.

So I think that knowledge building and training around these issues is really important across the system.

MS ABRAMSON: That's very helpful. Thank you. As I said I'd really welcome a submission on that. Thank you.

MR HARMS: I might just add one other point.

MS ABRAMSON: Of course.

MR HARMS: Which is because of the massive impact that a person's - the way a person is treated by others has on their personal identity and their experience of many aspects of recovery such as even hope for a better future, making sure that the informal carer supports are actually supporting recovery by developing them, providing family therapy if necessary, psychoeducation for sure, that's actually a crucial part of making an effective and cost efficient system, and so it shouldn't be seen as an option. We'd also note that the relationships that consumers have with their clinical advisers is equally important, and that's why the changing of mental health service culture to be non-stigmatising and to be warm and empathetic and supportive and so on is so crucial to eliminating seclusion and restraint, as well as to improving the outcomes achieved by those services.

MS ABRAMSON: Thank you, that's been very helpful and as I said I'd welcome a submission from you. Thank you.

MS SMIT-COLBRAN: Thank you.

MS ABRAMSON: Could I please call Mr Gye? If you'd be kind enough to state your - I'm sure everyone's heard it now - state your name and where you're from for the purposes of the transcript and invite you to make an opening statement, if you wish to do so. Thank you.

MR GYE: My name is Bill Gye. I'm the CEO of Community Mental Health Australia, and I want to begin by first of all thanking the Productivity Commission for this opportunity, and also as is proper to acknowledge country and the original custodians of this land and also to acknowledge anybody in the room with lived experience as well too, thank you for being here. Community Mental Health Australia is the national peak body for the eight state and territory community mental health and mental health peak bodies in each one of the states, and through them we represent 760 NGO organisations, assisting ballpark at the moment about 1000 people - 100,000 people with severe and persistent mental health issues.

My - I bring to this also too my own lived experience in having a mother who frequently went off to hospital with what they called a nervous breakdown in those days, and an overly friendly third class teacher, let me say, in a boys private school in Sydney and my own best friend's suicide at the age of 25 as well too, and as of last month 40 years' experience now in the community sector working in various different aspects. I obviously should begin by stating that there's been sufficient time to do a detailed analysis of this excellent 1238 pages including reference document, and that we will be submitting a more detailed written submission.

MS ABRAMSON: Thank you.

MR GYE: And at this stage the best that I can offer in the time we have is a tentative and general commentary on a couple of points.

MS ABRAMSON: Sure, understand.

MR GYE: Our original submission to the issues paper began with the statement that mental health is more than mental and more than a health issue. This makes it a complex matter as the subject matter refuses to stay within a single portfolio and requires outside the box thinking to really grapple with the psychosocial ecology of what we presently call mental health. The statement in the report that mental health services are tacked onto systems designed for physical illness speaks to this cross-portfolio reality.

The parable most applicable is probably the elephant and the blind man parable, if you are aware of it, where there's four blind men, it is a bit gender biased, who are exposed to an elephant for the first time and one is feeling the legs and one the tail, one the trunk, one the ears and one says, 'I know what an elephant is, it's like a tree', the one that's feeling the legs. 'I know what the elephant is, it's like a piece of rope', the one that's feeling the tail. 'No, no, you're all wrong' says the other, 'The elephant is actually like a giant palm leaf', the one that's feeling the ears, and the one that's feeling the trunk says, 'No, it's like a fire hose.'

And of course the reality is that they were all correct and it takes a long time to come to grips with the elephant and I'm sure you in your role here have heard many descriptions and important and impassioned pleas about various aspects (indistinct) and none of us can at this stage claim to know the full extent of it. So we've been (indistinct) in our perceptions based upon those experiences we've had in life to our understanding, and we neither can escape that bubble that we also exist in.

First of all, of course, congratulations for the document and for the wealth of information that it now allows us to mine and trail through in order to be able to reply with a hopefully cogent written response. But it's our initial view that at this stage the report has failed to come up with a new encompassing vision for mental health. As someone once said you can't - you don't invent the electric light by - the electric light bulb by continuous improvement on candles. The dilemma always is, of course, do I design a new house from a blank sheet of paper, from first principles, or does one have to work practically with the reality of the Lego pieces that are on the table before one.

This is not unlike the rebuild versus the renovate choice put in the report, but rather than applying that choice just to the issue of funding and governance it would be wonderful if we could articulate choices regarding the broader matter of the whole system design. We will comment more on this in our written submission, and what I will say here is that the three levels of: (1) primary mental i.e. shorthand for GPs, (2) secondary mental health, i.e. hospitals, and (3) tertiary mental health, i.e. specialists, are all founded on level zero, the ground zero of mental health which is community mental health, understood broadly as the mental health of the community for the community by the community.

It's the social and emotional wellbeing that our wise original owners of this land counsel us to consider as the embracing (indistinct) for those that are familiar with the approach that has been taken in many indigenous - many indigenous communities but also in the Australian indigenous community. In this framework we are social beings and our individual circumstances and conditions are largely though often invisibly the downstream effect of the wellbeing or

otherwise of the communities, including families that we live work and play in. It's a systemic approach to prevention and early intervention. This framework includes, but has more than the standard list of social determinates, housing, employment, et cetera.

As the (indistinct) of the recent - recently released New Zealand wellbeing budget, which I committed to you for inspection, had found there is not one portfolio that was not relevant and GDP in the New Zealand treasury policy document now is only a subset of their wellbeing index measuring national progress. If people have trouble grappling with this, and it is difficult, that's exactly the point and it's - and a situation where broad thinking is required and it's (indistinct) and does require some time until we converge critically down into what specifically is needed. So I apologise if some people might go: what the hells he talking about right now?

So I'll try and be a little bit specific. So as said there's been positives in the report, but I'll just focus on a couple of areas that we think is missing, incomplete or missing, or incorrect I should say. Missing, incomplete or incorrect. Firstly, unless we've missed it, the notion of trauma informed care is not mentioned in the report anywhere except in relation to ATSI services, Australian and Torres Strait Islander services there, and in that regard of course the current simple mantra of the field and a lot of consumers is don't ask what's wrong with me, ask what happened to me, and without that perspective we're missing an important chunk.

There's also no mention at all of non-traumatic at home crisis interventions, like open dialogue, though there are now three trials in Australia of that particular approach and that can come from either the community sector or it can come through a revision of the traditional asserted outreach approach there, but the benefit of it coming from the community sector is that there's a different relationship than there is between that and a health authority, and that seems to be a secret component of success rate in the evaluations of open dialogue. Mostly importantly though the need for a robust non-clinical recovery support workforce is not there, and by non-clinical I do not mean to put and us versus them implication there.

Indeed that traditional division between clinical and non-clinical is actually probably more unhelpful now than helpful there. There's many a service out there and run by an NGO service where there's CBT coaching and mindfulness training, as well everything else, social participation et cetera. So the boundary between what is traditionally thought of as clinical and non-clinical now are very broad, and so to that extent it may be best to think in terms of what's required necessarily and - rather than just what sector delivers it. But as I was saying though, what's an important omission in here is that there's no addressing in the work - the chapter on workforce development and elsewhere on the workforce employed particularly by the NGO sector working in the recovery support area there.

Using the figures - or there is a brief mention, I should say, of low intensity therapy coaches, so the peer workforce of course is including in there but not the other. In the PC document itself, it does state that in 2017 there were approximately 27,000 working - people working for the community managed organisations in the psycho-social service area. Our view was that it probably should be closer to about 30,000. By comparison, in 2017, there was 3,369 psychiatrists. Again, not that it's an 'us and them,' but to just give you a sense of scale and difference there.

As I'll mention in a moment, the community sector has been through its own traumatic transition in the (indistinct), which was quite damaging, and it was an example of poor change management, and we have lost a significant degree of intellectual capital, and that's a shame, because it had grown very well over the last 15 years, and a lot of taxpayers' dollars went into that, and I think, as I will mention, it was probably based on some overly-rosy assumptions on the transition rate that people go into the NDIS. And because of that, we – a number of people have left the sector, there's been restructures there, and probably somewhere in the order of 15 – 10,000 to 15,000 people with several mental illness have disappeared back into the woodwork which took a long to contact them, which is a very shame.

Now, the work force is – this work force is very important, and their ongoing skill development is vital to a future society with improved national wellbeing, and particularly for those disadvantaged. And the work force needs can be worked back from three principles: (1), if you clarify the outcomes needed specifically for economic and social participation, and maybe even a measure of self-effort (indistinct) measures, that will in turn define the competencies that you need for those outcomes, both inside and outside the NDIS, as this is also a matter for inside the NDIS as well, too, and that we don't want to just maintain people through care. We want to teach people to fish, rather than given them a fish, and that's an important difference between a lot of people's understanding of what people, either with disability or mental health, need, versus for those that have lived and worked in that area know what is actually required.

That's not to say that we – that the work force has those competencies now. Some do, but it needs to be articulated and then developed, because that will be the way we get those outcomes, and a component for that, of course, is the remuneration needs to be such that we can attract and maintain people with those competencies, and the transition to the NDIS has been another great blow to that, in that the average level of work in a lot of the NGOs has now had to go down from 3.8 down to 1.2, that's between 1 and 2, because organisations have had to shift their financial risk of going broke from their own bottom lines to staff. The casual work force has doubled, as well, too, as the able insight report recently showed, as well, too.

There was a mistake in chapter 12, this is a small point, in relation to the transition to the transition of the three previous commonwealth funded programs, that was partners in recovery, personal (indistinct) and support with day to day living in the community, and also that was the carer – the (indistinct) program that was also cut at the same time as well, too. What's said in the report there in one place – in one place it's correct, in another place it's not correct. I can give you the page reference there. It says that organisations providing those programs were funded to continue them – to continue those programs for another 12 months. That wasn't correct; money went to the PHNs, for the extent for each transition - - -

MS ABRAMSON: Sure.

MR GYE: - - - and not all organisations that were providing those were the lucky recipients of that funding, so it was a lot more messy than that. Some PHNs gave little, three-month funding to person by person, others were a bit more generous. So it's just a small error that I noted.

And lastly, the following issue is described, but a clear solution is not offered. It's probably my closing point, and arguably the most important point, really. It's a quote from the document itself, from one of the pages, amongst the 1,238 pages in there:

'Approximately 690,000 people have a severe mental illness. Approximately 64,000 of these are expected to be eligible for psycho-social support under the NDIS. While some of the others currently do and will receive psycho-supports, psycho reports find its review that the Australian state or territory Commonwealth governments, we estimate about 100,000 reinvestments. There remains a massive gap between the assessed needs and the services provided.'

So, 690,000, 64,000 which is 8 per cent of that of the NDIS, make it as best 100,00 currently getting services, and no clear – no clear plan for what we do, for what's now sometimes called the missing middle, and I'm sure you've probably heard that. But clearly, it's our big challenge, and one that governments will (indistinct) on, because I can't see any other way around it but extra funding, and a threat to surplus, but maybe in a longer term we should at least move towards it, and it should always be articulated, because the – while the political reality will be that we have limited funds, the long-term practical reality is that we must invest in prevention and early intervention.

And of course, this funding competes with emergency services and beds, which are always on the front page, and in an ideal world, of course you would do both, but I can't see – I still see that the practical reality is these will compete with each other. So my view is that whatever is recommended will be filtered by political compromise, so I would hope that the Productivity Commission in their prudence can push it forward hard on this long-term investment approach to prevention and early intervention, but of course the governments will work backwards and compromise everything from that point onwards. Thank you.

MS ABRAMSON: Thank you, Mr Gye. I just have our apologies that we've got one of the programs not quite right. It's more because we do things at that big level, but there are obviously regional variations. One of our difficulties with the community mental health workforce is that's it a really broad category, and we struggle to pick up the variety of job names, there was little consistent or comprehensive data on how many people are doing what, and what the measures of outcomes were for consumers. So we're really asking the sector to give us a bit of help with this.

MR GYE: Could do. Now, the great tragedy there was that in – a lot of work was done over the last 10 years to produce what was the NGO minimum data sets, the MDS. And it was ready to go, and what it would have given you, through the Australian Institute of Health and (indistinct) all those particular numbers. Now, you may or may not know that it got up in Western Australia, for awful design by strategic data in Melbourne, and it's still being used by the Commission in Western Australia. It partly got up in Queensland, there, but it then faltered and remained in the in-try of every other one of the states, and the Australian Institute of Health and Welfare, their protocols require at least a minimum of three states to submit their data, before the data is put up on their national reporting. They've asked for quite a while, 'Could we just have one more state?'

So because of that, our sector's invisible, it's been invisible, and that was also one of the explanations why, I think, the transition from those commonwealth programs that I've talked about was done as well, because people didn't know – perhaps didn't have clear idea of the signs. I won't be critical of the Departments, because I know they each have their own stories and some of those people are my friends, so I won't be too hard on them in their absence, but I still say, I think there was a failure to collect the data and report it, and in fact there is a sad story of failures that resulted in that, and certainly the sector itself could and should try to do that, but it really should have been part of the contractual requirements, over many years, to give the – give the decision makers, particularly the principle committee, those numbers, so that they could steer properly, and knew also of the downstream – you know, the effect downstream of that data not being there.

So the best we – we can make some guesstimates, at the moment, right now, but I can see that when you would have been collecting, you looked for hard data from the usual resources are not there.

MS ABRAMSON: Yes, absolutely.

MR GYE: But it's still, it's there, and happy – well, we will do our best.

MS ABRAMSON: (Indistinct).

MR GYE: (Indistinct) as best we can. There's a bit of a flip to move towards that NDIS data, to miss the – one of those torturous acronym sub-departments to the principle committee there, the one to do with an information strategic planning, so there's something afoot to make that happen. But yes, no, it is our greater issue. We've been invisible, and are invisible, and it's a real shame, because I think, particularly in regard to those three programs, and I will sound like I'm repeating myself, in my view, and in my years of experience, those three or four programs were one of the best created mental health programs that we've invented in this country over many, many years, and they work really well for consumers, carers, and it's a shame – what one should do when stepping across a slippery stream is not take your weight off the rock you're on before you've got your weight firmly on the next rock, and we hopped rock thinking that it was going to be there, and it turned out to be slippery or wobbly, and as you three will probably know, only 25 per cent at this point in time have been in those programs, which was at one stage 50,000 people, have ended up in the NDIS at this point in time, they're still swimming towards it.

MS ABRAMSON: Thank you. I've just got one more question, Mr Gye. I wanted to ask you about carer respite services. We're quite interested in this area, but we'd like to know what type of services, how should they be targeted, and of course the funding. Happy for you to take it on notice, if it's something you want to think about.

MR GYE: I will. I'll just speak off the cuff on a couple of remarks, and also pick up on the presentation that was done before, which was great. Certainly, it's in alignment with the broad comments I was making before about not having the focus exclusively on the individual, and what's happened to them, but putting them in a social context, and putting families in a context of communities. We have atomised it to nuclear families, but in those areas and those

communities that still keep extended families or other networks of community, there's a – there's a context in which families are apart, and not just a nuclear component of their own.

More specifically, I think the involvement of carers is essential and complex, because each situation is actually different, and often you've got people with inter-generational issues there, which is – which have maybe been undiagnosed, on the one hand. On the other hand, you've got people who have worked their entire life, doing extraordinary service there, and worrying what they're going to do when they pass on, the people who you were looking after.

As was mentioned before, in psycho-education, and where necessary family therapy are also a great adjunct, as well, to that. But respite, you know, respite services are still very important, and we tended to – we were moving towards that, and we tended to brush that way. That can work very well in the NIDS. If you're lucky enough to be a NDIS practitioner, that can be – that can actually work. When you asked – this might be interesting – when you ask carers what's the number one thing they do for respite, it's actually to improve the recovery and independence of their care recipient, of course, though it is still nice to have some opportunity for some (indistinct) to take over, just to give you a rest for a couple of days, I think is important.

So respite, psycho-education, family therapy, engagement of carers in the process, if you can get around those tricky confidentiality issues, and I agree, too, the open dialogue method I mentioned, as well, too, is more general for families. It's a very traumatic experience for a family to have the police or something come on in, and sometimes literally drag your care recipient out, and the damage that does both to the person and the other person, is ginormous to me. I have genetic trauma from that, and it's extraordinary. So I do commend open dialogue, and/or if we had the funding, we did have in Australia a wonderful (indistinct) outreach component in several areas of Australia, but Northern Sydney, actually, was one of the – was at one time regarded as one of the best in the world, and it's been a terribly downhill step by step, funding by funding, position by position not being filled, money going to the big machine that goes 'ping' and we're cancelled (indistinct) and those little behind the scenes hospital decisions.

So we've had it. And we could recreate it again, but we get back now to the governance and the funding issue that's so important, because we need to provide some assurity that when you put something together, we're not going to go through what I'm essentially saying. We've been there, and done that, and we're happy to impart (indistinct) wheels of things that have gone well, but the wheels have fallen on.

MS ABRAMSON: Thank you, Mr Gye. Thank you so much.

MR GYE: Thank you.

MS ABRAMSON: Can I just ask, before – I understand we have one person that wants to talk to us, in camera? Is that right, Henry? Before I do that, could I just if there's anyone from the floor that would like to have an opportunity to speak with us? Doesn't look like it. Could I thank people for their participation. Can I particularly thank people with lived experience who have come forward, and I understand it would not be easy to do so, and that's been most welcomed by the Commission. The Commission is now going to sit in camera, so if I could

ask everybody to leave the room, we'll take a short recess for five minutes or so, and then we'll come back in. Thank you.

**MATTER ADJOURNED UNTIL
TUESDAY, 26 NOVEMBER 2019**