



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

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

TRANSCRIPT OF PROCEEDINGS

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DR RAMU NACHIAPPAN — GP

JO-ANNE COLE

PROF KING: So I'll get started. Good morning. Welcome to the public hearings of the Productivity Commission inquiry into mental health. My name is Stephen King and I'm the presiding commissioner on this inquiry. I'd like to begin today by acknowledging the traditional custodians of the land on which we meet today; the Barkandji people of the Barkandji nation. I would also like to pay my respects to Elders past, present and future.

The inquiry started with a reference from the Australian government in November 2018. The purpose of the inquiry is to present recommendations to government in May next year for reforming the mental health system. It's incredibly broad. Any of you who have had the pleasure of having looked at our draft report, which came out on October 31, we've a thousand two hundred and something pages and we know we haven't covered everything in there; we know there are gaps so, really quite interest in a wide ranging discussion today.

We've talked to representatives of Australian state territory governments, service providers, peak body's unions, academic researchers and individuals with an interest in the issues and held round tables throughout the inquiry. Most importantly, we have talked with consumers and carers, and if there are consumers and carers here then, thank you for attending.

We've released the issues patroned in January and we've talked to a range of organisations and have received 573 submissions since its release. We're grateful to the organisations and the individuals that have taken the time to prepare submissions and to appear at these hearings and, as I mentioned a couple of weeks ago, we released our draft report.

So the purpose of these hearings is to provide an opportunity for interested parties to provide comments and feedback on the draft report, facilitate public scrutiny of the Commission's work and to get feedback on the draft report. We like to conduct all hearings in a reasonably informal manner, but I remind participants that a full transcript is being taken. For this reason, as I said before, if you want to make a comment you have to be around the table because the black mics are just for the transcript. If you give a comment back there, it just ends up being a blur.

As I mentioned, by the way - well, as I haven't mentioned, but just a point. I don't expect everyone to have sort of said, 'Yes, I remember the recommendation.' If there's anywhere where you say, 'What did you do in this area?' just ask the question and between the three of us, I think we can probably remember every recommendation in there or, if not, take a pretty good guess.

MS ABRAMSON: Yes, should be.

PROF KING: I remember them all.

MS ABRAMSON: You remember thousands and thousands (indistinct).

PROF KING: No, no, just the wrecks. This is the eighth public hearing of this inquiry. Following this hearings, hearings will also be held in Rockhampton, Brisbane, Launceston and Adelaide - and Darwin I thought; yes, okay, it's missing on here.

We will then be working towards completing our final report having considered all the evidence presented in the hearings and submissions, as well as in other informal discussions.

But for those planning to lodge a public submission we vet feedback on the inquiry draft report. The closing date for submissions is 23 January 2020.

Can I by the way just encourage people, if you've got any thoughts following up today, just pop them in an email and send them along. That's all, you know, a submission doesn't have to be anything fancy and it's really important to get the input.

MS ABRAMSON: (Indistinct) comments.

PROF KING: And comments, yes. We actually have a comment site on our web page. To find our web page is very easy; open your favourite search engine, which I usually say, 'Google' - but open your favourite search engine and just if you put in Productivity Commission - Mental Health, first page that comes up, certainly in Google, is the one you need. That's easier than trying to remember an address.

Participants are not required to take an oath but are required under the Productivity Commission Act to be truthful in their remarks. Participants are welcome to comment on issues raised in other submissions. Transcript will be made available to participants and will be available from the Commission's website within a week of this hearing. Submissions are also available on the website.

Any media reps? No? Okay, well, I can skip that bit. To comply with requirements of Commonwealth Occupational Health and Safety Regulation, you are advised that in the unlikely event of an emergency requiring the evacuation of this building - Henry to advise on the day - - -

MR WILLIAMS: Look, I'll get back to you on that.

PROF KING: Well, hopefully we won't have an emergency before morning tea. I suspect head down the stairs, and I'd be amazed if the place we're meant to congregate isn't the park across the road - Sturt Park I think it is.

Okay, so they're the introductory comments. Well, what we'll do is we'll run through questions in a minute and really get your comments, your ideas and we'll have this as a fairly informal discussion. We've got until about 12.00. We can run overtime until 1.00 if, you know, we've got really good discussion if people want to make comments, particularly for a consumer or carer and you sort of say, 'Look, I'd like to make a comment, but not, you know, in camera for example,' that is possible right at the end. But we do have to finish by 1 o'clock precisely because we've actually got to head off to another meeting.

MS ABRAMSON: Not everyone has to stay the whole time.

PROF KING: Yes, and people can come in and out as you please, yes. Let's start off, however, by doing a quick run around the table. For those at the table, if you can just say your name, where you're from and then, we'll kick off for discussion.

MS HAYMAN: My name's Jan. I guess I'm representing Lifeline Connects today. I'm a volunteer and, yes, my boss recommended I come here.

PROF KING: Excellent.

MS SMITH: Vanessa Smith. I'm the manager of the Broken Hill Community Mental Health, Drug and Alcohol service.

PROF KING: Yes.

MR WHITE: Les White, Lifeline (indistinct).

MS SANDERSON: Joanie Sanderson, counsellor in private practice.

MS HINTON: Maxine Hinton and I'm with Lifeline as a counsellor.

MR GOUGH: Peter Gough. I'm part of the Maari Ma Aboriginal Health Corporation, their social and emotional wellbeing.

MS McMANUS: Christy McManus. I'm the deputy director for Mental Health, Drug and Alcohol, Far West.

MS BEESTON: Glenda Beeston. I'm a teacher and I actually work in the area of - well, student welfare teacher, but now known as Teacher Wellbeing Programs and I have my position because I am against school counsellor positions here in Broken Hill and basically there aren't enough school counsellors. So counselling is mostly what I do.

PROF KING: Okay, first thing that I'd like to touch on and I think Henry - sorry, Henry and Ros - okay, Ros, why don't you introduce yourself.

MS BELL: Rosalyn Bell. I'm the Assistant Productivity Commissioner which basically means that I've got the team of people that produce the draft report and organise everything.

PROF KING: She's the boss in other words.

MR WILLIAMS: I'm Henry Williams. I'm also the Productivity Commission and Ros is my boss.

PROF KING: Ros is my boss as well. Okay, what I'd like to start off on first is you mentioned counselling in school, but I'd prefer to start off more generally, initially. One of the things that we're aware of is once you get out of the cities, and quite frankly, once you get out of, you know, Melbourne, Sydney, Brisbane and Adelaide, services can be thin on the ground.

Now, one of you in my discussions just over a coffee sort of said, 'Wow, actually we've got lots of service providers here, but they may not be as well linked as we'd like.' So I'd really like your reflections on what's the availability of services like here. What's missing? Is there enough interconnection and linkage between services? Is there the coordination there that we need? Then, we'll lead off from there. So I'm open; my only thing is, and it's going to make the transcript I suspect a lot easier if, again, for the transcript you can say, 'Glenda,' and then

launch into it rather than - I'll try and remind you but, otherwise, the transcript guys have got to try and remember everybody's name. All right.

PROF KING: So who'd like to head off?

MS BEESTON: Glenda.

PROF KING: Glenda? Okay.

MS BEESTON: All right; Glenda. Because I work in a primary school of about 250 students. It's one of the large primary schools in Broken Hill, but it also has a number of students who deal with a lot of issues, it has a lot of support classes. I can have anywhere between 20 to almost 30 students that I see who are referred to me through the learning support staff.

PROF KING: Yes.

MS BEESTON: So some of those students actually access other places like Maari Ma, CAHMS are seeing other services outside of what the school can provide and I've always found that generally people are able to contact me, sign a release of indignation document and we can talk about the child; what I'm doing for them, what they're doing for them. Yes, and I've also visited - I mean not very often because I'm not a skilled counsellor, but I'm kind of acting in that position - even have been down to Maari Ma to have meetings for certain cases. But it doesn't happen a lot, but it does happen. So that's my experience of it.

PROF KING: Okay, with the students that you see at school how much of the interaction - well, are you able to interact more broadly with the family or is that because you're in a school position.

MS BEESTON: No, I've worked in both high school and primary.

PROF KING: Yes.

MS BEESTON: In high school, students can self-refer to the school counsellor or to counselling basically.

PROF KING: Yes.

MS BEESTON: In a primary school you have to have parent permission. They have to sign a document to say that their child can, you know, see somebody and, you know, basically come out of the class and miss some education and that lasts for 12 months.

PROF KING: Yes.

MS BEESTON: And I speak to parents if there's a particular need. If I'm not just working on something, like, say anxiety or anger issues because a lot of the children that I deal with end up having behavioural issues in the class; not all, but some.

PROF KING: Yes.

MS BEESTON: But I can also speak to parents about what they're doing outside of the school setting and, yes, so I speak to parents as well.

PROF KING: Sorry, I'll keep on the education side and then we'll bring it more broadly in a second, so, sorry, Glenda.

MS BEESTON: No, that's fine.

PROF KING: How are the children - so you said learning and support sort of says - you know, it'd be a good idea if you see - - -

MS BEESTON: Well, we have meetings once a week. I mean schools are very well set up for actually meeting once a week, finding out what's going on across the school.

PROF KING: Yes.

MS BEESTON: So children are referred through that situation and I talk to the teachers as well, so, sorry, what was your - is that the answer?

PROF KING: So really how the kids - one of the issues in dealing with is often the in-classroom teachers know that there's something not quite right.

MS BEESTON: Yes, they do.

PROF KING: But in many situations, they don't know who to turn to. It might be different at your primary school but really, you know, they're not sure because they haven't had training. We don't want to put more burden on teachers quite frankly because they're pretty busy at the moment.

So we were thinking there needs to be a resource that comes into the classroom, sort of somebody with some training, who can then sort of say, 'Yes, there's something going on here which is more than' - - -

MS BEESTON: Yes.

PROF KING: You know, take an example of a student who's been performing and suddenly performance goes down, attention in class goes down.

MS BEESTON: Yes.

PROF KING: So, yes, there's something here. Let's provide a gateway so this student can now, and their family, can get the relevant help that they need. So how does that look?

MS BEESTON: I think that does happen very well in schools actually because teachers will notice something.

PROF KING: Yes.

MS BEESTON: They'll talk to other staff; they will then refer that - they'll talk to people about learning and (indistinct) teachers. People can come in and do observations if they need to. You've also got your - it's generally your school counsellor. So generally those cases will be talked about pretty thoroughly and that's how it works.

PROF KING: Yes.

MS BEESTON: In terms of teachers' knowledge of what the problem is with the child and whether there's just something different, I think there is a fair bit of training out there now, and I do think though that it'd be great if there was far more sort of social and emotional - like, I guess lessons placed in the curriculum. If that was something in the curriculum, I think that would be really useful for teachers because I think kids need to learn all that sort of stuff.

PROF KING: Yes, okay.

MS BEESTON: But I think in terms of referring students who seem to be having some sort of problem, I think the schools are pretty good at sorting that out and then, referring them on through school (indistinct).

PROF KING: Referring them out through the process, yes.

MS BEESTON: Referring them out to other institutions or (indistinct).

PROF KING: I'll come back to the social and emotional wellbeing and bring the rest of you in as well, but just on the referral out to services.

MS BEESTON: Yes.

PROF KING: Does it actually work pretty well around Broken Hill? Are there enough services? Is it, you know, a case, you know, particularly child and adolescent that you're saying, 'Oh, well,' you know, 'You can get a service but there's a six week wait,' or - - -

MS BEESTON: Well, we've got lots of great services here.

PROF KING: Okay.

MS BEESTON: But I think just probably volume is a problem.

PROF KING: Yes.

MS BEESTON: I may be wrong here, but I think that places like Cairns have to deal first with, you know, very, very young children. Certainly they will see other children as well. Maari Ma's there for people. I think, you know, again, it's just finding the personnel, finding the people and having enough, you know, people available to actually see the student for as long as they need to see people, like, headspace.

PROF KING: Is there a bit of a wait as well - we've had headspace.

MS BEESTON: Yes, I think it can be huge wait in places as far as I know.

PROF KING: Okay.

MS BEESTON: It's fantastic that we now have headspace in Broken Hill. But to access that you have to be 12 and up - - -

PROF KING: Yes.

MS BEESTON: Between 12 and 25.

MS HAYMAN: And can I just interject?

MS BEESTON: Yes.

MS HAYMAN: They only have one counsellor at the moment.

PROF KING: That was Jan, by the way; just for the transcript.

MS HAYMAN: Yes, my name's Jan.

PROF KING: Yes, I know.

MS HAYMAN: Yes, they only have one counsellor.

PROF KING: Have one counsellor at the moment.

MS HAYMAN: So she's really, really busy and quite often she's sort of - it's very hard to get appointments with her.

PROF KING: Yes.

MS HAYMAN: Yes, we don't have enough counselling services.

MS CALLEGHER: I'd like to speak.

PROF KING: Yes, so, sorry, if you can state your name.

MS CALLEGHER: I'm Jodie.

PROF KING: Jodie, g'day.

MS CALLEGHER: I'm basically work for the family counsel support service at CatholicCare.

PROF KING: Yes.

MS CALLEGHER: Our engagement is with kids (indistinct) to 18 and we do get quite a lot of referrals with schools.

PROF KING: Yes.

MS CALLEGHER: Our fluctuation referrals I gathered is in regards to our capacity. We have two part-time workers; one full-time worker and we probably get around about anywhere from five referrals a week coming in. We don't have a wait list. We try to engage with those kids straight away. So we're an early intervention program, so I think that works really, really well with schools, like - sorry, Glenda is it?

MS BEESTON: Yes, Glenda.

MS CALLEGHER: Yes, Glenda, I apologise. Like Glenda said, we probably don't consistently get to all the schools in town, but we do go into most schools. We have one worker that goes out to - on a public school with - generally float around to most schools in town, whatever the highest of the needs of the schools at the time.

PROF KING: Okay, so not just the Catholic schools you go along to.

MS CALLEGHER: No, no.

PROF KING: Okay.

MS CALLEGHER: They're all public, we go to all of the - actually Catholic schools are the least of our school that we go to.

PROF KING: Right.

MS CALLEGHER: And that's basically because they're teaching - they have their own linked in counsellors and social workers and so they link in through Skype and they get a lot of their referrals and stuff, get their kids sorted out with online stuff.

PROF KING: Okay.

MS McMANUS: Could I just make some comments?

PROF KING: Please; so again, name first - sorry Christy

MS McMANUS: Yes, sorry; Christy.

MS BEESTON: I'm mentioning all these other (indistinct) .

MS McMANUS: Yes, so, thank you, Glenda because I appreciate that. So I work for the Far West Area Health, so I speak on behalf of CAMHS. So, yes, they do take higher acuity and higher risk clients and more complex clients trauma history. So age is not such an issue, it's about the presentation.

I think, and it's really good to hear about your service, because that's probably not something that I was not aware of - I feel, like, there's that gap between schools and CAMHS referrals because CAMHS can't pick up - even though they're fully staffed it's not a matter of - all their positions are filled - it's just a matter of not being able to take the lower acuity referrals.

MS BEESTON: Yes, that's true.

MS McMANUS: And the other comment was, yes, school counsellors are able to kind of identify and screen and know when someone needs to be referred. But I'm aware that not all the schools have school counsellors and sometimes these positions are vacant and that becomes a gap that health then sometimes are asked to come and fill or we get referrals that aren't as appropriate.

We do have two positions that are School-Link Coordinators and they're a link between our schools and health. One of them is vacant at the moment, but in the town of Broken Hill with the amount of schools that we have, the job is just spread to thinly I think and it's sort of - they try to focus on one school but be available to others, but I just don't think that the - it's hard for those positions to work effectively across all of the schools.

PROF KING: Can I then come back to the service navigation and interlinking because I'm going to pick you up on a comment you just said that, 'Well, I didn't know about that service.'

MS McMANUS: Yes.

MS CALLEGHER: CAMHS knows about that service because they refer to us regularly.

MS McMANUS: Right.

PROF KING: Okay.

MS CALLEGHER: So they'll look at a child and they go, 'Okay, they're not high needs,' and we'll send them straight over to them.

MS McMANUS: Yes.

MS CALLEGHER: So we do get referrals from them on a regular basis.

PROF KING: Okay, so coming back, though, Glenda, to the school, is it - - -

MS BEESTON: Yes.

PROF KING: I mean how do you decide where to refer to? Because you wouldn't know if CAHMS is full or if CatholicCare is full.

MS BEESTON: I wouldn't in my position.

PROF KING: Okay.

MS BEESTON: The school counsellor would decide that, yes.

PROF KING: Okay, and do you know would that be done I mean despite local knowledge or to get some (indistinct) - - -

MS BEESTON: Ideally with the schooling coordinator, yes.

MS McMANUS: Yes, that would ideally be the connection there.

PROF KING: Yes, so that's a position that currently exists or that's one - - -

MS McMANUS: There's two that currently exist.

PROF KING: Yes.

MS BEESTON: Yes.

MS McMANUS: And one of them is filled and one is vacant.

PROF KING: Okay, yes.

MS McMANUS: So one focuses on the high schools and the one that's currently vacant, focuses on the primary schools.

PROF KING: Okay, and that's the coordination link there?

MS McMANUS: Yes.

PROF KING: Okay, coming to the social and emotional wellbeing programs, because you mentioned, 'It'd be great if we could have more social and emotional wellbeing programs in schools' - - -

MS McMANUS: Yes.

PROF KING: Do you want to expand on that in the sense that - - -

MS BEESTON: All right.

PROF KING: What do we need more in our schools to help our young people?

MS BEESTON: Well, I think it'd be great if there was a wellbeing subject where kids learn about, you know, the signs of the world, the advantages of sleep, good diet, values.

PROF KING: Yes.

MS BEESTON: And actually also learn about things like to be able to I guess label things like depression, anxiety. Learn ways to self-regulate, just that whole area of wellbeing which

is, you know, relaxation, mindfulness. I just think that that would be great if that was embedded somewhere in the curriculum.

PROF KING: Okay.

MS BEESTON: So that students have a language to understand what's going on in their wider life and, you know, in families, amongst their peers. I think, you know, we hear a lot about mental health and we see advertisements on the television that sometimes that's presented I think as something outside of what's a normal life.

PROF KING: Yes.

MS BEESTON: Whereas I think it's very much part of the lives - like, school children, high school children for instance who might - if you look at any of the art works in Year 12, a lot of that's based on, you'll see, just them thinking about their issues, their problems, their anxieties, it's suicides through friends. I mean I think you need to give them some sort of forum in the curriculum for them to be able to talk about those things; learn about those things and possibly, in the future, then be able to prevent some of those things for themselves or if those problems do come up for them, feel confident that they can go and get help for that.

PROF KING: Yes. Well, there is money for - I think all schools receive money for social and emotional wellbeing programs and they seem to differ significantly between schools. Any thoughts on that? Yes, I'll give the worst example we came across where apparently there was one school who, because they were meant to report a number of hours for social and emotional wellbeing programs, they reported recess.

MS BEESTON: (Indistinct).

PROF KING: So that's an extreme.

MS BEESTON: Yes.

PROF KING: And I still haven't been able to confirm whether it's a war story, but it's a great story. So thoughts on that? Is it more funding that's needed? We get told the curriculum's too full. We can't fit it in.

MS BEESTON: That's true.

PROF KING: Is it the relevant teachers that are needed. What's missing? Why can't we do that?

MS CALLEGHER: Yes, I think that, like, in the Broken Hill area they do try to do that, you know (indistinct) interest. We have all of the organisations meet together, we have YSSI meetings with (indistinct) meetings which we all get together and we do stuff for the high schools. So we have programs that go into the schools to help support the teachers to have those outcomes around wellbeing, around anger issues. So we've got lots of different programs that go into the schools from - Mission Australia runs some, CatholicCare runs some, CAHMS I think are looking at going into some.

So, you know, we have identified that pretty quickly. I've been in the (indistinct) health support service for 10 years and one of the things that I have been doing on a regular basis - and obviously I can't get to all the schools - is a program around resilience, changing the way we think, how do we be more positive, friendship groups. The program itself is called Friends for Life which doesn't give it the right name because the kids actually think that it's all about being a friend to people, but it's not about that. It's about resilience and being a friend to yourself and having an understanding of your emotions, and it's a curriculum-based program and it can be run in a school base. So it can be run from as young as four, right up to age 12 and then goes into adult resilience.

So I've been running that one pretty much in the town for the last 10 years on and off. Obviously I can't run it to the whole schools, but I have touched based in lots of schools and I find that the schools are identifying that that is a need; it is definitely needed but it's about the capacity of teachers being able to run stuff in their class and from stuff from the community and everything like that.

This particular program, they have changed it a lot over the years, and it became online so which becomes quite hard. We've modified it a little bit, we did, you know, it's quite to do online when you're out in a rural community, especially places like Wilcannia and Menindee and things like that.

So it's just finding that, like, program for the schools that fits that school's needs. So each school and town is different.

PROF KING: Yes.

MS CALLEGHER: Like, one particular school might need stuff on peer relationship and so that's what they'll need from us and we go in and run little snippets of programs. We run self-esteem programs, wellbeing programs, anger programs, I think we've got about - we also do some in the preschools. So we do another little program called Little Highway Heroes and that's all about emotions. But obviously play-based; that sort of stuff.

PROF KING: Yes.

MS CALLEGHER: And I think health has been running that a little bit as well with their nurses, so the nurses that go into the schools.

PROF KING: Can I pick up on one point. So you immediately started talking about more than one program with the different offerings.

MS CALLEGHER: Yes.

PROF KING: One of the things we've heard talking to particularly school principals, so the reaction is, 'Yes, I'd like to do more, but there's all these programs and I don't know which ones will work and which ones don't.'

MS CALLEGHER: Yes.

PROF KING: And quite frankly, we've talked to some providers of programs who I'm not sure that there's any evidence that their programs have any affect whatsoever, but again, the school principals don't know; I mean they've claimed in this area. So often they'll choose a program by going and talking to other principals or other teachers or people who have got some experience. Would it be better to have - do we need to help the principals themselves to work out, well, what are the needs in the school and what programs we need in this school.

MS McMANUS: I think so.

MS CALLEGHER: Yes.,

MS McMANUS: And I think you're original question was, 'What do we need?' I think I feel like we need more of a structure. So for our School-Link Coordinators they would be happy to run programs, but I would like to see that one of your roles is to run - there's these options of these five programs that we're going to train you in, and across the state, all of our School-Link Coordinators are trained in these five evidence-based programs and we deliver these based on depending on what schools need and so that there's a consistency across the state in evidence based programs, so we're not sending people off to another training and we come back, and we've got 10 people in the town trained in 10 different trainings and they can't deliver them together because there's so much variety.

PROF KING: Yes.

MS McMANUS: I just think if we had a bank of evidence-based programs that we agreed upon, we could be so much more effective in our delivery.

MR GOUGH: Just to speak to that, Mr Commissioner, the - - -

PROF KING: Call me Stephen, by the way, not - - -

MR GOUGH: Sorry, Stephen. Maari Ma runs school-based programs specifically for Indigenous kids.

PROF KING: Yes.

MR GOUGH: At last count, there was close to 300 programs operating in Wilcannia - well, over the last few years there's 700 people.

PROF KING: Sorry, 300 different programs?

MR GOUGH: Sorry, so there is a little bit of overlay (indistinct) want their principal.

MS McMANUS: Yes.

MR GOUGH: That's not just school-based.

PROF KING: Sorry, that's 300 school-based programs or 300 general programs?

MR GOUGH: No, 300 overall programs.

PROF KING: Okay, but still - - -

MR GOUGH: 300 (indistinct) so there is a huge amount of confusion and sidelining that goes on. There has to be a way to integrate all programs, but there is not.

MS McMANUS: Yes.

MR GOUGH: Everybody has their own - I won't say agendas, but they've got their own values and their own mission statements, which is wonderful and admirable, but it's definitely overloaded out here.

PROF KING: Okay, by the way, just for the transcript; that was Peter.

MR GOUGH: Sorry; Peter.

PROF KING: Yes, no, I completely forgot to so my apologies.

MR WHITE: Les.

PROF KING: Yes.

MR WHITE: I have a question here for Jodie and Glenda, but they're (indistinct) was why education? How many of you know of Life Education and some of them (indistinct) have heard of them and had a lot (indistinct) in schools and whether there's still connections at all with the schools with Life Education. Do you remember the program?

MS BEESTON: I remember Harold well.

MR WHITE: Okay, so you we've got three there, yes.

MS BEESTON: Yes, I don't know whether it's still running. Sorry, Les.

MR WHITE: I was involved in Life Education when it came to Broken Hill right from the first meeting that was called.

PROF KING: Yes.

MR WHITE: I got the (indistinct) Life Education then at that meeting and supported it for the full 10 years that it was involved in Broken Hill and I to me, at that time, that was the program that was set up to educate kids from when they first started school, right through to high school and then, I think later on it was actually implemented into some of the high schools. But I'm of the very firm belief that if you grab children earlier enough and start to educate them very, very early in their lives, that you can make a difference in their lives and over the years I've met people and asked that question of how many people, you know, when Harold comes

up or Life Education comes up, how many of you saw that program, and are you familiar with the program at all?

PROF KING: The details, no; but I've heard of it.

MR WHITE: Yes, right, you've heard of it?

PROF KING: Yes.

MR WHITE: It was basically taking kids from healthy eating, healthy care of yourself, not smoking and all that sort of thing.

PROF KING: Yes.

MR WHITE: We took the van at one stage up to Menindee to the old mission site up there and opened it up and set it up for the full day and the parents were invited to go through with the kids that were there and, of course, the kids wanted to come too, 'Look, mum, look, dad, look what we saw; this is what we see,' and of course, mum and dad went through at 100 miles an hour. They didn't want to see it because basically what it was saying was if you moderate and cut the smoking out, moderate the drinking and all that sort of stuff, to educate the kids early enough.

I'm not too sure how many lives hopefully that program would've saved, but they didn't seek the program out here because, as I said, I used to do all the maintenance on the vehicle. It was a (indistinct) that was two thirds the length of this room and had all the gear set up and they used to close the room off, and in the ceiling, there were all diamond-shaped - like, star-shaped holes and when you turned the lights on they were just lights, you know, from the stars.

PROF KING: Yes.

MR WHITE: And then they had this program teaching the kids about smoking and that sort of thing. I'm not too sure, when I look around and see the number of people that are smoking, how successful it was but it was basically grabbing the kids early in life and teaching them how to care for themselves, like I said before, healthy eating but - - -

MS McMANUS: Christy; I think it also had - the thing that I liked about it was the protective behaviours, children being able to talk about keeping their body safe and things like that. So I agree; I think that's a good example of a really positive program and that's one of many and I guess that's about how do we all navigate many of these amazing programs.

MR WHITE: Well, I'm actually interested now, is there anything that took the place of Life Education in the schools now?

MS McMANUS: Not so holistically that I can think of.

MR WHITE: Because that was very broad, but it was one of those things that we had the educators out here and they were very good at their job. My concern was we had to make sure that we supported the educators as best we could because we were taking (indistinct words) it

was always the young lady and she would come out with the van, she would be shipped out in (indistinct) usually - not all of them but some. Then we would send them out into the bush to (indistinct words) and all those places and take this vehicle on all the rough roads and all that sort of thing. It was well supported by Gary Rathburn and quite a few other people in the district, who as you can imagine it's a (indistinct) it's a full semi-trailer.

So (indistinct) shifted, and it was shifted by Bradfords and quite a few – like I said, quite a few of the other people. They did this stuff free of charge, and I did my whole ten years work on it free of charge until the last year that it was here. They said to me, 'We'd like you to put in a bill', I said, 'Why?' They said, 'When we moved the van around to all the other places we get accounts for \$1000 for this and \$200 for that and \$700 for that, when it comes to Broken Hill, there's no record of what's spent on it. But I said, 'I do give you a record of what I've done', they said but there's no cost involved, 'So give us a cost for \$30 an hour or whatever the going rate is then give us a bill for what you want', right. So I put it in as a dollar an hour and then donated the money back to - - -

PROF KING: Can I ask – because one of the things that you've raised and has been raised by others, is are different schools and different communities, and I'll broaden it out a bit to the whole community, have different needs, different requirements. To what degree do we need different approaches, not just depending on the school community but also – well, does what works in town, would it work in Wilcannia or does it need to run from a different perspective. How much does, you know, whether it's a school program or whether it's a broader provision of social or emotional wellbeing at the community level, how much does that need to depend on the community that they're serving?

MS McMANUS: Christy. I would imagine that our early intervention programs could be similar across areas. But Wilcannia's got a high indigenous population.

PROF KING: Yes.

MS McMANUS: And I think the programs that we run there need to be culturally specific and appropriate to that population.

PROF KING: Yes. Other thoughts, yes?

MR WHITE: Les (indistinct). Talking about Wilcannia, in particular, when they contacted me and said we're taking the van away and no longer be coming out your way, I said, 'Why', they said, 'The cost.' I said, 'So what's the problem?' They said, 'We can service five or six kids on the coast for the price of servicing one in Wilcannia and Tibooburra but particularly Wilcannia.

PROF KING: Yes.

MR WHITE: And I said, 'Well wait a minute, you're telling me that the life of the kid in Wilcannia is not as valuable as the life of the kid that's on the coast?' And they said, 'We're not saying that.' I said, 'Wait a minute, you are saying this – exactly this, the life of the kids in Wilcannia are not as valuable as the one's on the coast. We can service five over there for one

out here.' I said, 'I can't see – I can't see how that can be so, you know, the life of the kid in Wilcannia is just as valuable as any other kids on the coast.'

PROF KING: Yes.

MR WHITE: But I was very angry about that. They said, 'What we're going to do is, is replace the program with taking an educator and putting them in a station wagon, load all the gear on that' and they did that. And they did that for a while, they were coming out until a few years back. But reading about the program would be in the back of her station wagon, whatever she had she would (indistinct words). But the great thing is you would be able to me, Christy, your feeling of when you were in the van and how – what an impact it would've had on your life.

MS McMANUS: Yes, look, I think it was a great program. So I – yeah.

MR WHITE: But I know that things run their course.

MS McMANUS: Well, I guess it's – is that the program we're going to focus on but whatever it is that I guess we focus on, it would be nice if it was consistent and it would be nice if we – and there needs to be sustainable, I guess. And that's – and I don't know why that stopped but for whatever reason, whatever we look at needs to be sustainable - - -

MR WHITE: They told us it was money because I visited the – the base of Life Education and actually did a job while I was over there, had a breakdown on part of the (indistinct words) audio visual stuff and I fixed that because I've actually worked on it on the van.

PROF KING: Can I ask, so we've heard from indigenous communities by indigenous Australians, that really to get culturally appropriate programs and again they could be school book, they could be community, really that means that there's got to be community control or it doesn't always have to be an indigenous controlled organisation but that's the preference, if the relevant services can go through the indigenous community controlled organisations or indigenous controlled organisations, then they're likely to be much more effective. So I'd like comments on that.

MR GOUGH: It's Peter, we run a number of programs, mainly for adolescents throughout high schools here and Wilcannia.

PROF KING: Yes.

MR GOUGH: And have – and my colleague Karen, who runs those has had outstanding results on the culturally based programs such as – the one that comes to mind is Seasons for Growth.

PROF KING: Yes.

MR GOUGH: Managing the adolescents and the engagement, probably A for her personality and she's not indigenous but does a wonderful job. As well as the relevance and the cultural relevance of the content, and sees kids even in Wilcannia turning up time and time again to

participate, where a lot of the times those programs participation is minimal at best. So there are programs out there and that's just one that I mention, that are, if they are cultural appropriate and (indistinct words) which is identified by the community themselves, whether that be the teaching community or the elders within that community, such as, (indistinct) relationships and teenage pregnancies, people are interested.

PROF KING: Yes.

MR GOUGH: It's not just, 'Here's a program, and we run it'.

PROF KING: Yes.

MR GOUGH: As is evidenced by about 300 (indistinct words). I think the other issue is the efficacy of those is really measured, I think. So I hear my colleague over there talk about the program, sounds a wonderful program, but in this day and age of financial, I suppose, management we have to measure the effectiveness and I find that there's a lot of research that goes into these programs that they are obviously (indistinct) otherwise there wouldn't be any air time but the – but the actual results is very subjective and self-serving for some people who may not have done so well. So I think there has to be a focus on the academia side to measure the result and it also has to be culturally appropriate. Not just indigenous culture but they listen to country and western music out here. It's not the inner-city where a lot of the policy makers tend to reside. They are a different culture by being removed and (indistinct) isolated.

PROF KING: It's also – I mean, just on the cultural part, so for example, I kept picking on Coburg in Melbourne just because - - -

MR GOUGH: It's easy.

PROF KING: - - - that's an area. My wife's a clinical psychologist, by the way, (indistinct words) and so she works with a lot of the Islamic women – not that my wife is Islamic but she's Indian and they're simply – you know, she grew up in a country which has, whatever it is, 350 million Islamic people so she actually understands the cultures and being brought up there for some 20 something years. So in Coburg you also need culturally sensitive and relevant services. It's just the culture is different and so I think that's one of the challenges of making sure that, you know, because even the concepts of mental health differ between communities and differ depending on cultures. Can I – sorry, I've now lost my train of thought on that. I'll do online – no, I'll do suicide next. Des, if you can introduce yourself, by the way?

MR JONES: Yes. My name's Des Jones, I'm (indistinct words) Chairperson of (Indistinct) Aboriginal Housing and Chairperson of (indistinct words). But I think I've been (indistinct words) conversations going on but I think the realities out here in the remote section around mental health is some communities are blessed with services but there's been no audit of who does what, who's eligible to access those services within aboriginal and non-aboriginal, you know, so we need to do some auditing around who's actually providing services, what are they and I think, you know, there's an emerging issue around, you know, social media and all this sort of stuff that's a different type of – not (indistinct words) different emotional well-being, sort of, issue that's emerging in our community and dividing some of our families, dividing some of our community. So we need to understand what's actually going on now with some

of the stuff that's happened previously around the issues that affect mental. And I'm no expert in (indistinct words) family, you know.

PROF KING: Yes.

MR JONES: But I think with the experiences we've seen, like, there are some resources (indistinct) resources out there that are available for non-clinical programs, mental health and social, and emotional well-being and there's also the clinical approach. So you've got to marry them up somehow and make sure that they are, there's some sort of pathway of flow for people, so that if I access a service, it links me into other services, you know, I just don't get (indistinct) for the sake of the funding, do you know what I mean, and I've seen it happen, so. So we need to be mindful of all these things that happen when people put submissions in access resources. And, you know, I've seen a lot of the 70/30 sort of mix where 70 per cent admin, 30 per cent service.

PROF KING: Yes.

MR JONES: So when you look at how do we make that work (indistinct words) because if it's about, you know, building your structures, it's not about the clients? So we really focus on what the client needs are and the community, so (indistinct words) communities around their priorities, I suppose, around what they see as their priorities as community action plans, we call them. So they should also be respected in the planning process and have a look at and be included in that whole discussion around what are the best things that happened for those communities because, you know, Broken Hill (indistinct words) live the next street is different, don't worry about the next town, do you know what I mean?

PROF KING: Yes.

MR JONES: So we've got to be aware of (indistinct words). So we're all not doing this sort of, you know, on the same wave length, I suppose. Stephen, the big one for us and we've raised it for years around mental health is, over the Easter period you've got four days of nothing, do you know what I mean? But (indistinct words) something like that. So that's got to be fixed up somehow or any public holidays where people that are – whether it's a family or whether it's the client, require a service.

MS HAYMAN: Jan. I agree. Over Christmas.

MR JONES: (Indistinct words).

MS HAYMAN: Yes, a week or two, you can't access any services at all.

MR JONES: Mental health doesn't take public holidays, does it?

MS HAYMAN: Yes, it doesn't take a holiday, exactly right.

MR JONES: So we need to be mindful of that so those people do get access to – including their family members without being the first port of call in severe cases of police, you know.

(Indistinct words) that rock up to the door and sometimes that can be too regular which means it makes matters worse around the client anyway.

PROF KING: Yes.

MR JONES: That the police are called to (indistinct words) as a first responder. So somehow we've got to change that.

MS McMANUS: Yes. Christie from (indistinct). So speaking from (indistinct) I don't know what other services run on public holidays but from Far West Mental Health Drug and Alcohol perspective, we don't have our clinicians on the ground on public holidays. But we do run an after-hours emergency service. So what that looks like is we have links with Orange and it's a teleconference – it's a tele-psychiatry and counselling service, so people would (indistinct words) come to our emergency department with acute presentations. And they would be - - -

PROF KING: As in the hospital's emergency department, yes. Okay, yes.

MS McMANUS: Yes, the hospital's emergency department.

PROF KING: Okay, yes.

MS McMANUS: And that would result in a tele link with Orange for that assessment and we also have an on call psychiatrist that runs 24/7, so that service would contact our on the ground on-call psychiatrist who if required is available to come in. So if there was an admission to our in-patient unit or anything like that then (indistinct) continues to run. So probably what, over public holidays does stop is the response to lower acuity presentations and I can't speak on behalf of any other services if anyone else continues to operate on public holidays. But from our perspective that's how we run the service.

MS SMITH: Vanessa. Also for the outlying areas the same procedure where people could go the local health service and access that video conference and psychiatrist service.

PROF KING: Okay - - -

MR JONES: And (indistinct words) with mental health don't leave their seat, you know.

MS SMITH: That's right.

MR JONES: So we've got respond to this in a different way.

PROF KING: Yes.

MR JONES: You know, it may be (indistinct) services that want to work over the public holidays. We don't know yet but if (indistinct words), you know, so (indistinct words) we can do that, you know.

PROF KING: So how do you make that doorway though, particularly, you know, public holidays or out of hours services, how do we make it affective because as you said it's not just

an issue in the bush, it's also an issue in the cities where someone may be just not feeling well, they're deteriorating, there aren't the services there because they're not ready, you know, they can't rock up to the hospital. The hospital would say, 'No, you're not sick enough to be here', until it really goes bad and then the police are called and they're taken along to ED and ED is not a great place with mental health issues. How do we – how do we – sometimes that gap - by the way it's referred to as 'the missing middle', but you know, if you can get – if you can be in community in town, you're well enough to deal with a counsellor or a psychologist, that's fine. Down at the other end, if you're bad enough the police take you to a hospital and you can get the services but there's nothing in between. So how do you think we can start to fix that sort of issue, because the last thing you want is somebody to deteriorate to the point where the police are called?

MR GOUGH: Peter. I think that all our services here bar the – bar West Health is sub-acute. So we are not emergency crisis situations.

PROF KING: Yes.

MR GOUGH: Although we do get crisis presentations regularly. So in many respects the reason why I'm sure my colleagues across the road don't open on public holiday is they haven't got enough funding to open through the week let alone public holidays for staffing. So with penalty rates, the cost of that, trying to protect their people who, you know, they're on the (indistinct) all the time with very little time off to give them some quality time to recuperate and regenerate, is paramount. However, there's no funding for wages for that.

PROF KING: Okay. If the funding was there, would the workforce be there?

MR GOUGH: Possibly, there would be some people who value their time off, some people who can manage their time in a different way, so - - -

PROF KING: Yes, I'm slightly a different direction. If you were going to run a 24 hour service you'd need more counsellors, you'd more psychologist, and you'd need more social workers.

MR GOUGH: I suppose it's like a lot of public sector organisations that stay open, such as even the police force.

PROF KING: Yes.

MR GOUGH: Some people want to work those days to make some money and they'll have other days off. You know, they might be more interested in school holidays than public holidays. So I think that's very doable but I don't necessarily think that going to the – to the organisation and handing out the money, saying 'Can we have some more income for wages just to cover stuff', I don't know if that's going to actually achieve any results.

PROF KING: Well it depends if they come up with the money, I guess.

MR GOUGH: Exactly. You know, everybody runs on a shoestring, I don't see anybody driving around in flash company cars.

PROF KING: Yes. No, no one of the benefits of the Productivity Commission is that if we've got the evidence to sort of say, 'Look if you spent an extra million dollars here, guess what guys, you'd be saving this many lives and you'd actually be saving public hospital admissions and the benefits are multiples of that', you can - - -

MR GOUGH: I'm completely focused on that funding model and not one to say just throw money at it but I think in that respect it's sort of - - -

PROF KING: Yes.

MR GOUGH: Yes.

MS McMANUS: Could I - - -

MR JONES: (Indistinct words) you do or you don't, you know.

PROF KING: Yes, that's right.

MR JONES: It's going to cost you so you might as well do it. I think – I think, like I said earlier a lot of it doesn't have to be clinical. So you can have community programs done on the weekend so these people can access that service if they're not feeling too well or if they feel (indistinct words) and access it. But it's preventing it – preventing it to get into a crisis point, you know what I mean?

PROF KING: Yes. Sorry - - -

MS SANDERSON: Joan. This is just going back to the school thing, I'm sorry. But I think that we need to learn something from first nation people and – about I think sometimes our programs right across the board have become fragmented because we're always trying to reinvent new things and I think we need to go back to basics. And instead of going out I think we need to come back to simplicity and, you know, a beautiful indigenous man I was talking to one day said to me, 'You white fellas have too many words', we have to – you know, we want to bring it back to simplicity.

And I think when we're looking at children's programs whether it's in Wilcannia, you know, having things around or Menindee but also in Broken Hill, I think we need to go back to basics and instead of trying to invent new things we need to bring it back to simplicity and start from the ground up and look at how can we make this simpler. So instead of having all these fragmented programs that are out there and nobody knows why I do this or why I do that, because we've already got that on the internet and there's all these choices and everybody's brain is going at a thousand miles. I think we need to bring it back to the simple things, you know, on the ground, what's needed and run it out right across Australia, all the programs but just tweak it with different communities.

PROF KING: Yes.

MS SANDERSON: But just have it so that it's easy accessibility to everybody.

PROF KING: Yes.

MS SANDERSON: And so, you know, you don't want to put more pressure on teachers, like, you have to, you know, you have to pick a program. Like, just have it so that it comes back to basics again. So anyway, that's - - -

PROF KING: No. In some ways that's a good summary of, sort of, where we've been heading which is to say, we want to make sure that there's evidence behind the programs. So at the national level, we've suggested to the National Mental Health Commission, 'Actually evaluate the program, and work out what works, where the evidence is.' And then at a local level basically says, 'Look here's a list of programs that works at a local level, choose which ones you think will best match the needs at the local level.' So that's sort of what we're (indistinct words) about how to do that simplicity which you've been saying.

MR WHITE: Les. Just a question for Des. Des, you still have indigenous liaison officers employed in the police, do you?

MR JONES: Yes. There's a community liaison officer there.

MR WHITE: Community liaison officer, I'm wondering how well they're trained?

MR JONES: Their roles are different, their liaising people, do you know what I mean?

MR WHITE: Yes.

MR JONES: They're not actual referral people and all that sort of stuff, it's about just - - -

MR WHITE: Because they really should be the first person on the scene when they're called to a domestic or something like that. That then they – they should be in first – they should be part of the – the first responder work, shouldn't they?

MR JONES: Yes, I (indistinct words) situation, I think it depends on what's going on.

MR WHITE: Yes, because that's when a lot of the – that's where a lot of the trouble would come from, I imagine, that (indistinct) more concerned, like I said before about the younger ones (indistinct words) called to a household where there's a teenager or even younger than a teenager causing strife. Whether there's somebody there that knows how to handle that situation and the – like, people saying that a number of programs that operate in Wilcannia, I'm just – I mean, I did hear at one stage there were 60 agencies in Wilcannia at one time. You know what I mean, and that I thought to myself at the time, how ridiculous is that?

PROF KING: Yes.

MR WHITE: You know, you surely don't need 60 different agencies trying to function in - - -

PROF KING: Yes. No, we did look at more broadly at services provided to indigenous communities about four years ago and the worse one we came across is that there were more service providers than there were people in the community. I can't remember which community it was, I think it was in the (indistinct words) somewhere. But yes, it was – it was interesting that - - -

MS SANDERSON: Could I just add – sorry, I was just thinking of - Joan. Like, from what I observed in the community, now people have to apply for funding for this and that, it then becomes about having to tick boxes so that you don't lose your funding. And the ticking boxes sometimes becomes more important than the people that you're actually servicing and I have seen that right across the board. That's where I'm really happy that I work for myself because I don't have to – because I just think, you know, workers are having to spend so much time in the office because they're – and they'd rather be out on the ground working with people but because of the funding bodies they have to answer to them and it becomes about the ticking the boxes, and they have to have completed all these things. But you know, what's happening to the people on the ground that the funding was actually given for?

PROF KING: (Indistinct words). Yes.

MS McMANUS: Yes. There's a couple of comments that have been made and Des said, 'Yes, we've got lots of services but we've got this heavy admin component, there's only a few people doing the job.' I feel like that's what I've – we find, there's – there's lots of services available but when you contact there's a wait list or they're full (indistinct) whatever, so that actually each service doesn't necessarily have the capacity to meet the needs even though there's a lot of services. So the other – I agree Joan about the ticking boxes and funding and I think we're seeing more of that.

Back to talking about after hour supports and the Aboriginal liaison, on one of the recommendations 16.1, was whether or not we put mental health professionals or clinicians with the police department.

PROF KING: Yes.

MS McMANUS: My thoughts on that was that maybe in Broken Hill, I don't feel like that could – would be a full time role. But I certainly think it would be absolutely helpful to have someone that – that was a focus of their role, for example. And that they were available to police to be called out to attend those scenes, and I thought maybe – sorry Broken Hill, Wilcannia and Menindee, the far west.

PROF KING: Yes.

MS McMANUS: I don't know if having someone sitting in the police station waiting for those would be a good use of their time.

PROF KING: Yes, is it a good use of resources, yes.

MS McMANUS: But I think it is a good position and maybe it could be spread across a couple of other – other services. And the next thing I was going to say, I can't remember, so I'll come back.

PROF KING: Could – sorry, yes.

MR JONES: There's a lot of energy in the back of end of services, you know - - -

PROF KING: Yes.

MR JONES: - - - got to happen before someone (indistinct words) service. So and – and we need to (indistinct) all that first in order (indistinct words) whose doing what because the data will tell you that's what their focused on, those areas, all right?

PROF KING: Yes.

MR JONES: I'm talking about that (indistinct) stuff, you know, all the upfront non-clinical approaches where they don't go - - -

PROF KING: Yes.

MR JONES: - - - appear on the radar, you know, and - - -

MS McMANUS: Yes.

MR JONES: - - - match them up in (indistinct words) so if you can remember (indistinct words) you know, our community is not functioning, you know or functioning well (indistinct words). And all of a sudden (indistinct words) influences come in, you know, like the alcohol, drugs, the social media stuff, high unemployment, you've got all these things that compound on what happens in a community and it affects a lot of people too. And if you're struggling families are – are being torn apart by mental health or other things, all right, well where's the services to get them without being clinical, to – just to support them before they get to, you know, because the police shouldn't be picking up all the pieces. You know, they're an enforcement agency, they're not a social (indistinct words). If we're going to make sure what's on the ground now is actually working.

PROF KING: Yes.

MR JONES: And if it isn't working, do something about it.

MS BEESTON: Could I just jump in there, Des. I think – I just think needing people on the ground and needing people in a community who know the community members who know the youth in a personal way, I think youth workers, the employment of youth workers and those sorts of people would be really, really useful. Because they – it's not just about going to a service and getting help, I've got this (indistinct words). I think, you know, relationships are a huge factor, like even in education, if you've got a relationship with a child you're going to help all the family, yes, you're going to help them far more.

And I think, apart from a whole lot of sporadic little things happening or going (indistinct) and that (indistinct words) help, if you've got people on the ground who have a personal relationship and a youth worker - and often I think it has to be males, I hate to say that, but I think that would help enormously. Some of these communities could employ those people who live in the community, know the (indistinct) the kids, know the adults, know the families and can actually then be a soft entry point also for people that do need help that, as you say, some people they don't (indistinct words) sick, they don't know they need to present, and it gets to that point where they're already at crisis and - - -

MR JONES: And (indistinct words).

MS BEESTON: - - - before you pick them up. So I think you need youth workers (indistinct words).

MR JONES: Or family workers, people who work with families.

MS BEESTON: Family workers, yes.

PROF KING: Yes.

MR JONES: But it has to change (indistinct words). We can't continue down this path, you know.

PROF KING: Yes.

MR JONES: The more resources you throw at it, the bigger the problem seems to get, you know.

PROF KING: Yes.

MR JONES: I think it's about how we do it better.

PROF KING: Vanessa were you (indistinct)?

MS ANDERSON: You know, I was just sort of thinking back about the, sort of, availability of like a kids services for like public holidays and what not. But, you know, the idea that we have some sort of tiered approach available in the community. Currently we have a – Mission Australia run a program called Connections which is a social, an activity program that's run after hours and on weekends that support people with mental health issues, you know, people can come along and partake in that. So there are those types of services that available, I don't imagine they're available for public holidays and extended periods. So given that the feedback we're getting about those services that they're working really well and people are finding them useful, if they could have additional funding to be able to run, plus perhaps the step that's then missing is something that might be between a service like that and the emergency department or the police. So, you know, having other perhaps, you know, clinical people involved in a service like that. That would then - if the person did need to go to the ED they could support them to go to the ED - - -

PROF KING: Yes.

MS SANDERSON: - - - and make a sort of - a more effective (indistinct words)

PROF KING: So it's not handcuffs and the police taking you in, yes.

MS SANDERSON: Precisely. So they could sort of advocate and facilitate a more helpful experience, yes.

MR JONES: Make it (indistinct).

MS McMANUS: Christy. And one thing that I think of that's obviously happening is the zero suicides in care funding and one of the initiatives of that is the Safe Haven Café model that we are strongly supporting. So an alternative to an emergency department where a more early intervention approach that would be available after hours, on weekends, ideally public holidays, that would be run by peer or people with lived experience or peer workers, youth workers even. I love that idea. But with a trained clinician who is then able to identify if something needs to be escalated to the emergency department.

But that police and ambulance also would have an option or if they - you know, went to a scene or something and said: do you want to - do you want us to drop you down to the Safe Haven Café? You can have a coffee. You can have a chat. You know, ideally it'd be Aboriginal peer workers that's there as well. That would maybe prevent or be an interim step to a more acute mental health (indistinct).

MR JONES: And this follows on from that for me. Most people that are in that space don't care what worker it is, you know, Aboriginal or not. They just want some support. So the more - the more support or the relationships that person has got in a department - - -

PROF KING: Yes.

MR JONES: - - - that's the first one they'll respond to when it's (indistinct words). The (indistinct) are having a lot of divisions in our communities now. So, you know, not even on the same sort of wavelength or relationship. The right person will be - will be the right person because everyone gels with that person based on their skills, and you see that (indistinct) people go to people that they trust. People comfortable and are safe, you know.

UNIDENTIFIED SPEAKER: Yes.

MR WHITE: Les, from Lifeline. I'm - sorry.

PROF KING: No, no, Les, you go. I mean - - -

MR WHITE: I've been involved in Lifeline for over 30 years, and I spent 16 years on the telephone.

PROF KING: Yes.

MR WHITE: And to me that's the first port of call. That people have got to get to - quite a lot of people they get to the stage where they've got the rifle under their chin, which I had one guy. He had it there for 45 minutes.

PROF KING: Yes.

MR WHITE: And after 45 minutes took the bolt out and I said, "What was that noise?" and he said, "That was the bolt coming out. I'm not doing it today, but I'm not saying I'm not going to do it."

PROF KING: No, no - - -

MR WHITE: "I'm not doing it now" and that's what the thing is. We'll need to have somebody that's available now.

PROF KING: Yes.

MR WHITE: Not 9 o'clock tomorrow morning until 5 o'clock tomorrow afternoon.

PROF KING: Yes.

MR WHITE: It's now at 3 o'clock. I used to get a lot of my calls at 3 o'clock in the morning.

PROF KING: Yes.

MR WHITE: You know, 4 o'clock. The phone actually started - I can remember when I took over at about 10 o'clock, the phone would ring when I walked in, and you would be on the phone continually. So I got to the stage where I actually had to hang the phone up for a few minutes to give myself a break, to get that - - -

PROF KING: Yes.

MR WHITE: - - - that call out of my head, so to be ready for the next.

PROF KING: To focus on the next one, yes.

MR WHITE: But, you know, you - that's - I feel that Lifeline is - fills the bill there, but of course that needs funding. It - - -

PROF KING: Yes.

MR WHITE: - - - will need funding.

PROF KING: Can I - Peter, can I - I'll come back to you in a second but just before coming back to you, because we've sort of danced around technology a few times. So telephones obviously old style technology. I think having counsellors or clinicians available through Skype call type of thing, so it's through the internet and other - to what degree - but we also mentioned say having youth workers, people on the ground. To what degree can we use

technology, and again I'm thinking, you know, the police liaison person or somebody - yes, we don't necessarily want someone sitting in the police station 24 hours a day, but you do want somebody the police can say, look, we've got an incident, can we use technology to try and help overcome these sort of barriers to getting the services where we want them.

So any thoughts on that and then I'll come - Peter, okay, lead on.

MR GOUGH: It's an area I'm very passionate about. Sorry. Peter. I was a policeman for 21 years, an inspector working in remote and rural New South Wales. Worked in Bourke, Cobar, Griffiths, Moama and up the north coast. So very specific indigenous populations with different cultures. With my view on this now being in the psychology world, ACLOs aren't designed for mental health. So we've got to discredit that. ACLOs are from the community, and if they're involved in a mental health incident there will be a conflict of interest there. I work with people in this town who are conflicted with their family being involved, not wanting to disclose mental illness, let alone letting it all out there. So confidentiality - - -

PROF KING: Just ACLO, just make sure, Aboriginal Community - - -

MR GOUGH: Aboriginal Community Liaison Officers.

PROF KING: Yes, I thought I'd better get that on the transcript.

MR GOUGH: They're from the communities, they're not trained. The police have actually got a great mental health network. If there is an issue there are people that they can refer to on call all the time. The police are only called as a last resort. So it's obviously family first. They're very conscious of that. I'm not standing up for the police just my understanding of transition. If that doesn't work it's ambulance.

PROF KING: Yes.

MR GOUGH: If it becomes violent or not intentionally violent but through somebody not wanting to go, that's when the police are called, and that's purely for transport.

PROF KING: Yes.

MR GOUGH: So it's not for - if they have to restrain it's for the right reasons. It's not for any other reason.

PROF KING: Yes.

MR GOUGH: To get them to a safe environment where they can be treated by medical people, because it's a medical problem.

PROF KING: Yes.

MR GOUGH: It's not a law and order. So they're purely transport. So I don't think having people with the police to go to mental health incidents is of any value at all now, because it

will be ambulance officers there. There may well be a CAMHS team or a critical response team. In regards to - sorry, were we moving on to Telehealth?

PROF KING: Technology, yes.

MR GOUGH: I work at Wilcannia Hospital once a week and my mobile phone doesn't work in there. So good luck with that.

PROF KING: Yes. All right.

MR GOUGH: I've worked for Corrections in Victoria. I've worked on - in Telehealth. But these people were forced in, say somebody is in Mildura and I'm in Shepparton or somewhere like that.

PROF KING: Yes.

MR GOUGH: It's okay at best. There is no better counselling than face to face.

PROF KING: Yes.

MR GOUGH: To develop rapport, trust, the hand gestures, just the environment. It's very stark when it's in front of a TV screen.

PROF KING: Yes.

MR GOUGH: Now I haven't met Des yet but working for the same organisation and my cultural knowledge, which is expanding daily, is that I don't think it would work in indigenous communities. I don't know what your thoughts are Des, because they value communication.

PROF KING: Yes.

MR GOUGH: It's about relationship and rapport. There is a place, I think, once that rapport has been developed, I do it now where I have phone consultations with clients, but I've already formulated that - that rapport. So in relation to counselling I think yes. In regards to treatment I think no. Because proper CBT, proper DBT - sorry, therapies - - -

PROF KING: Yes.

MR GOUGH: Cognitive behavioral therapy, dialectical behavioral therapy, especially for trauma ridden communities like this, require some tools. It requires some white board, it requires handouts, it requires interaction and explanation, and I don't think Telehealth does that when we're talking treatment. It may well for counselling, and I've done some great counselling sessions over the phone. So we have to delineate between (indistinct). So if there's a person in trauma well you've got to be with them because their whole world has been corrupted and it's that personal interaction that must be established.

PROF KING: Yes.

MR GOUGH: So plus I can't even ring out from Wilcannia. I can't even get even get Netflix at home (indistinct words). So maybe with some little - as the time develops.

PROF KING: You mean you're not on the NBN?

MR GOUGH: No.

UNIDENTIFIED SPEAKER: (Indistinct) don't want that.

MR GOUGH: We're still on dial up.

PROF KING: I want to ask Des about, you know - just if you can comment on Peter saying look it might be different for indigenous communities and some other communities I expect and because of that need for a rapport, and then I want to run a model past you that we've seen elsewhere and see your views on that and then I think we probably better grab a coffee. Des, what's your view on - so about Telehealth that - - -

MR JONES: Well to me they'll (indistinct words) for all the suicide cases that have happened, did they have access to a mobile phone. Did they (indistinct) mobile phones. Is that - you know what I mean? So I think it's more - it's more the educational stuff around Facebook is out there - around the stigma with mental health and supporting the family unit because the family unit is the first responder. That's - they're first one that really respond to episodes and whatever, they're in the family area I suppose of that environment. But I think it's understanding, because that to me when it explodes it's not because of that there and then, something happened previously or something that's happened a while ago, you know, so it's not - to me they just - it's a trigger, some little trigger that triggers an episode and it might not be coming to this meeting, it might have been something that happened somewhere else.

PROF KING: Yes.

MR JONES: Come here and something sets up and it's just exploded and that's (indistinct), but as I've said I'm no expert in that field but observing it all you think a lot of this can be prevented by engaging with family. Educate the family around what mental health and you know the things - behaviours that can trigger episodes. You know what I mean?

PROF KING: Yes.

MR JONES: So, I mean technology is important. A lot of people understand technology and how to use it, unfortunately some will be using it the wrong way, but I think it's about trying to strengthen the person and the family first, you know?

PROF KING: Yes.

MR JONES: So they don't feel isolated because I mean (indistinct words) isolated straight away. So I think the family understanding what's going on as well.

PROF KING: Yes.

MR JONES: Because if you don't understand - if you never been - - -

PROF KING: Family, yes.

MR JONES: - - - (indistinct) got no idea what's going on, you know?

PROF KING: Yes.

MR JONES: So your first call is (indistinct words) but there may be other ways of doing it. I mean technology is great, but not everything else is going to - you know, a computer, you know, or access to that, they rely on their social workers or their community workers that are on the ground all the time. So I think just beefing up that communication (indistinct words) for those who access (indistinct), what's on the - you know, what you Google nowadays. I mean you can Google and have a look at it but there's no emotional thing on (indistinct), I mean.

PROF KING: Yes.

MR JONES: It sort of doesn't - nothing better than a hand on the shoulder and say "you okay?" you know?

PROF KING: Yes.

MR JONES: You can't get that from technology, you know.

PROF KING: Yes, from the screen, yes.

MR JONES: So we need to fix that side up, that's the human side I suppose.

PROF KING: Yes. Can I just run past - because I don't know if you've got anything equivalent here so I'll just be interested in your views, and then we might take a break. We started to get into areas which relate to suicide prevention and I'd like to touch on that after you grab a coffee. There's a group out of Toowoomba who - Frontiers? What's it called? No, Rosalyn is looking at me blankly, she can't remember a name either. She's not sure which one I'm talking about.

MS BELL: (Indistinct words).

PROF KING: Sorry?

MS BELL: Outback (indistinct).

PROF KING: Outback - yes. Sorry, I can't remember the name of the service, but we actually visited them, I think it was Longreach when they had the floods there. It must have been February this year. So they'd gone from drought - I remember they'd gone from drought to flood. So, you know, people who had managed to keep their stock alive, all of a sudden their stock were drowning to death, and they actually worked on a model where they sort of had the counsellors and when there was an incident and when there was a need they'd fly the

counsellors out. So they'd literally fill up a charter plane, fly the counsellor, get into the community, talk with people in the community. Set up relationships over a period of a couple of weeks and then continue on through using things like Telehealth and using the technology.

So I guess one thing - Outback Futures. Thank you. So we were both right. I thought it had outback in it, and you thought it had futures in it. So I was wondering is there anything equivalent here? Would that be a service that would be worth thinking about - okay.

MS LATHAM: Hello, my name is Vanessa.

PROF KING: Sorry. You have to come up to the table though because - - -

MS LATHAM: Okay.

PROF KING: But bring a chair up. Bring a chair up.

MS LATHAM: (Indistinct words).

PROF KING: It's purely that it's on the transcript, so - - -

MS LATHAM: My name is Vanessa, I'm the manager of mental health, drug and alcohol services for the Royal Flying Doctor Service here. So we have a base here in Broken Hill.

PROF KING: Yes.

MS LATHAM: And regularly fly out to - it's about 17 or 18 sites in the far west, a little bit into Queensland and South Australia.

PROF KING: Yes.

MS LATHAM: With a GP, dental services, mental health, drug and alcohol. So we fly in and work from New South Wales health facilities in the little towns, Tibooburra, Wilcannia and Menindee or into station properties or really small towns and just set up the clinic there.

PROF KING: Yes.

MS LATHAM: So the mental health side of that's being going for about 10 years. So - and I guess we do use a lot of telephone kind of to support the face to face. Some places we only get to once a month. Other places we get to once a week. So that's quite good. I'm not sure really what else - I think we can't really replace the human person to person contact, but I think the telepsychiatry at that very acute (indistinct) level is wonderful that we have that, but yes all the levels kind of up - - -

PROF KING: (Indistinct).

MS LATHAM: - - - to there. That human to human kind of contact, and I guess another big thing we're doing at the moment in partnership with Lifeline is identifying - this is drought funding, so identifying pastoralists at the moment living on the stations and giving them basic

training. But these are people that are already - they're already kind of demonstrating their advocacy in mental health, putting themselves out there and they're already supporting their peers and we're supporting them to keep doing that.

PROF KING: Yes.

MS LATHAM: Giving them basic training like that (indistinct) counselling, and a few other Lifeline provided courses, and I guess just trying to really build that - the capacity of the - and a workforce of people living out there, and so probably looking ahead just different training and development opportunity with all of our local services to give that opportunity to different community members, different cultures. I think that's probably a big investment sort of - and partnership opportunity we can all continue with. Don't know, do you want to add anything else, either of you?

PROF KING: But it's interesting in some ways, I'm not sure if you were here at the beginning but we've sort of come a full circle in that we were thinking, you know, well started off in schools, need to help kids, get training in resilience in social and emotional wellbeing, those sorts of things, and really what you're almost saying is well it doesn't stop at school level when - you know, when you've got communities where you know there's going to be stress perhaps due to drought, perhaps due to other factors, trauma, I know there's been a number of suicides here so I suspect there's communities in stress around Broken Hill at the moment.

What you sort of want to do is actually have people trained on the ground, not as clinicians, but with enough training so that they're able to at least provide an effective doorway for someone to be able to say, yes, you know, the are you okay but not, you know - the problem with the are you okay sort of approach is what happens when they say no?

MS LATHAM: Yes.

PROF KING: And you're saying well, yes, we're training to train people so that if someone says "no, I'm not okay" they're actually able to do something. They're able to respond but perhaps (indistinct) - - -

MS CROSSING: Can I - sorry, I'm Kayelene, I'm counsellor, Warra Warra Legal.

PROF KING: Yes.

MS CROSSING: So Aboriginal legal service. I'm actually a mental health first aider trainer. So I go into communities and deliver mental health first aid training.

PROF KING: Yes.

MS CROSSING: To community members, so they're able to counsel each other I guess when we're not around, which in the New Year I'll be - I'm only new in my position, a week new.

PROF KING: Yes.

MS CROSSING: And I also used to work at Maari Ma as well, so I've got a lot of experience within the community as well.

PROF KING: Yes.

MS CROSSING: So delivering that, yes, training I guess is giving the hands on, so Bob Smith down the corner can actually give that first initial I guess one and one accidental counselling to be able to get - and then get supports in straight after that.

PROF KING: Yes. Any feedback on how well that works?

MS CROSSING: I've only run a few courses myself.

PROF KING: Yes.

MS CROSSING: But the statistics show that it does help to an extent. I guess it's a matter of if they're wanting to help that person or not as well, so - but I deliver it to a lot of other service providers as well so it's - and then, yes, a bit more, like I want to go into the schools and do it with the teachers but it's a matter of getting the teachers two days free.

PROF KING: Yes.

MS CROSSING: It's a two day full course.

PROF KING: To be able to train - - -

MS CROSSING: Yes.

PROF KING: Yes. Okay. Look we'll break for coffee. So thank you very much for that, and apologise for the formality of having to come up to the table, it's because of the transcript. So if you're not at the table the transcript can't capture the comments. So let's have a break for 10 minutes and pop back in. Thanks.

SHORT ADJOURNMENT

RESUMED

PROF KING: Okay, a couple of things that I'd like to get onto now. I'd like to talk a bit about suicide prevention, issues of suicide, what we need to do to – lots and lots have been done in suicide prevention in this country over the last 10 years and the rate hasn't dropped. So clearly whatever we're doing isn't working. So I'd like to get some ideas, what you think might work in Broken Hill and all the rest.

Issues of stigma, we haven't really talked about that yet, so I'd like to have a bit of (indistinct) there. Some workforce issues, I think Jennie and – sorry, someone else was wanting to talk a

bit about workforce issues and mental health nurses and so on. So let's head in that direction. As I said at the beginning, if you do want to speak, feel free to just pop down, grab a chair if there's a chair free, or drag your chair down. But you do have to state your name and come down here to make a comment. And I suspect I'll probably – Henry's probably running around like sort of saying, 'No, all these people need to register, and so on,' which (indistinct).

Now, Des, we had a chat over morning tea, then. Did you want to make a couple of comments to start us off?

MR JONES: Just on the technology.

PROF KING: Yes.

MR JONES: And like I said to Stephen, what's happening today is a lot of young people are – they haven't got wi-fi, access to it. They would go to a spot where there is wi-fi, it might be a supermarket or places that have it. But they're moved on because of the perceived risk or whatever it is. And I think, you know, that affects a lot of them, because there are – they're moved on, or the police are – someone, if a shopkeeper rings up, that they have to move them on.

PROF KING: Yes.

MR JONES: And the kids are saying to the police, we're only here for the wi-fi, you know? But there's been a call obviously. So in that technology, there may be an opportunity to put those wi-fi locations in safe places, you know, or such or you know, where the kids can put up – not only the kids. A lot of adults haven't got it, you know, but they get a signal. They'll hone in on that signal and they'll stay there, you know, so there might be an opportunity to do something around how we utilise wi-fi with our services.

MS HAYMAN: And Des, they used to have drop-in centres in Broken Hill and things like that. They've slowly but surely completely got rid of anything like that. So kids have got nowhere else to go, especially on weekends.

I know one of the clubs around town, they were trying to run something on Friday night a while ago, but that obviously never got up. Or got (indistinct) or anything so that's probably one of the biggest problems we've got is the kids have got nothing to do. So yeah, they do try to find where this wi-fi is and then the business owners don't want them there.

PROF KING: Yes.

MS HAYMAN: Drop-in centres, something similar to a drop-in centre would be a really good idea.

PROF KING: Yes.

DR NACHIAPPAN: I suppose like your old-fashioned internet cafes in the early days.

MS HAYMAN: Yes.

DR NACHIAPPAN: Back in those days, I actually went there. If I couldn't get access to them then I wouldn't have had any internet. Whereas now everyone's got it on their mobile phones, but those who can't afford it and in a region like Broken Hill, I think approximately half our community does not have internet access that they ought to which is very prudent.

PROF KING: Sorry, Ramu, because otherwise the transcript guy's going to get very upset. If you could just state your name for the transcript?

DR NACHIAPPAN: Yes. Ramu Nachiappan, I'm a GP in Broken Hill.

PROF KING: Thank you.

MR WHITE: Please - - -

PROF KING: Yes?

MR WHITE: Drop-in centres were mentioned.

PROF KING: Yes.

MR WHITE: Uniting Church at the moment, and has done for probably the last 15 or more years, maybe even longer than that, they've run a drop-in centre. It's still running at the back of Wesley Church. You've got a guy that faithfully goes in there four days a week in the afternoons, sits there and waits for the people to come in, have a chat, have a cuppa, watch TV's and just spend some time. A safe place. And he's got one guy that comes in there that occasionally has mental problems and he's just there. He's made himself available for that many years. His mother used to do it as well. And he's – he used to do it with his mother and now he just does it. He just sits there. So there is a drop-in centre there, but there – it used to be in Argent Street and now it's moved up there behind the Wesley Church. But that's the sort of places we need, like - - -

PROF KING: Yes, community spaces.

MR WHITE: Like St Vinnie's for the meals and of course, that's – that'd be a good place as well (indistinct) but we do have places like Lifeline itself where people can go in and have face to face. Like we said before having someone sitting opposite you talking to you, looking you in the eye and putting a hand on your shoulder and just saying, you know, that's so much better than, like we see, technology. Technology can only do a certain amount. But we need to have that face to face and people there listening to you, you know?

PROF KING: So the other thing, just on the technology side, so again, some of you were talking to me over morning tea on that. One of the things that people have said to us again, what – mainly out bush where wi-fi can be pretty patchy, it's sort of saying well, if you have the internet technology and you want, you know, even if you've done the initial face to face, but then you want to do online counselling follow ups, need somewhere, you know, private that you can do that. So just thoughts on that, is there anything like that in Broken Hill?

MR WHITE: Yes, Lifeline.

PROF KING: So Lifeline. Okay. So, yes?

MR WHITE: That's what Lifeline is about here in Broken Hill at the moment. Different services. And of course, we do have that service where people can come in and privately, in soundproof rooms, sit there and feel free to actually - - -

PROF KING: Can they talk to any counsellor? Or just a Lifeline counsellor?

MS HAYMAN: No, just the Lifeline counsellor.

MR WHITE: Just the Lifeline's, yeah.

PROF KING: Yes, so if it was a – if you'd – say through the Royal Flying Doctor Service, you're being linked up with somebody but they weren't a Lifeline counsellor then, that you wouldn't be able to use the Lifeline facilities? Is that - - -

MS HAYMAN: That's something - - -

MS PICKETT: Sorry. I'll talk about that, sorry.

MR WHITE: Yes, good girl.

PROF KING: Yes, please. Come up, state name and - - -

MS PICKETT: Sorry, Marisa Pickett from Lifeline. We've got a great relationship with health and the RFDS, so we do work as a community. So we do have our Lifeline counsellors. But we're very happy if kids want to go out to the RFDS we can chat with Christy or Jodie, like, it's very much – we're not isolating people just to us.

PROF KING: Yes.

MS PICKETT: It's really a connection centre. So we're connecting to where will suit them best. So they might come in, have a chat with one of our counsellors. That will evaluate whether they can help them or if somebody's better off going elsewhere.

PROF KING: Okay.

MS PICKETT: Yes. Just on the technology. Lifeline Australia has just done a tech service. They've been trying it for three years and they've – it's from six – it was originally 6 until 10 at night, so people could text through. They've now extended it until 6 until midnight because of the demand. But what I found really interesting, we had Lifeline Australia vettings last week.

And they said 40 per cent of people texting said that they would never have picked up the call. So texting (indistinct).

PROF KING: Okay. Yes.

MS PICKETT: So I think you've got to remember we're all busy these days.

PROF KING: Yes.

MS PICKETT: And we don't always have privacy to make a call. Some people are lurking or doing something, it's – and they're feeling really crap. A quick text, so - - -

PROF KING: Does Lifeline have any data relating to that that we could use? Because what you're saying actually fits in completely with what we've heard elsewhere where people have said well, when you're talking about technology, you've got to think of, you know, phone, text, face to face, you know, just typing an email sort of thing. That – so you've got to think of all sorts of different ways that people react with technology and you know, so the suggestion was put to us, well, young people in particular, they want to text. They don't want to be doing a face to face Skype call. So does Lifeline have any data or anything?

MS PICKETT: They're just now getting all that data together. So it's been a pilot program for three years. And they've just – now the data's coming through. So they would be happy to share that.

PROF KING: That'd be fantastic. Because, yes, again, that – you know.

MS PICKETT: Well, they realised – as I said, it was a trial from 6 to 10 and the demand was huge. So it's now 6 until midnight. But you've also got to remember Lifeline doesn't (indistinct) funds. So we do a lot of this just with little dribs and drabs and so for us locally, because we've got a great relationship with Health and RFDS, you know, they support us in a lot of the ideas that we come up with. You know, so.

PROF KING: Yes. I think - - -

MS McMANUS: So, just on technology.

PROF KING: Yes.

MS McMANUS: (Indistinct) face to face is better at (indistinct) relationship, but then there are times where we require specialist services that were just not going to be able to get face to face in Broken Hill. So there are times when Telehealth is important. But I think that we know that there are evidence-based CPT programs. We know that they exist. What I think is that people aren't going to just go and join those off their own bat. Often it takes a special type of self-disciplined person to do that.

And I think you need a connection with a mental health clinician first who introduces the consumer to that program and maybe even sits with them for the first one and says, 'This is what can happen, this is why it's helpful,' or whatever. And then possibly offers a space for that to continue if that person doesn't have internet access at home or, you know, so I think that the connection needs to occur first, but yes, it would be great if we had the technology and the

rooms, the private rooms where that person says, okay, yes, I'll come back this time, this day and we'll do the second session of this online program.

PROF KING: Yes.

MS McMANUS: I think that – we've – I feel like I've said to a lot of people, here's a list of online programs that could be helpful and I – I've really (indistinct) that people go away and complete those.

PROF KING: So the gold standard as far as we can tell in this – in Australia, is a WA1, which is called Ports which is built off Linespot which some of you may have heard of, is an online program. But it works on the basis of generally the GP's the gateway. The GP says, 'Look, yes, you might have had some mild panic attacks, mild anxiety, you know, a bit of symptoms of depression.' The GP in essence refers you to the website and the initial approach en force is that it's not you go in and there's some engine that does it. They actually have psychologist at – you can communicate in any way you like. So it can be phone and it can be text or whatever, and there's a triage done. And they then do a proper triage to work out well, are the online services going to be able to help you? Or no, there's something more happening here.

Do you need to be referred in the community and then they will do the referral. Sorry, so I've now forgotten where I was heading with that.

MS McMANUS: Yes. So in some ways that keeps the consumer on track, because you've got a real live person saying 'This is what we're going to do next.'

PROF KING: Yes. And I'm not sure, have they done – have they publically released the evaluation, yet?

MS McMANUS: I don't think so.

MR WILLIAMS: There's an (indistinct) paper published.

PROF KING: It has been published?

MR WILLIAMS: Yes.

PROF KING: Yes. The evaluation though?

MR WILLIAMS: Yes, they're evaluating the program.

PROF KING: Evaluating the program, yes. So it seems to be pretty successful.

MS McMANUS: And again, it's not going to fit every consumer and it's still going to – still targeting, sometimes I think your higher level functioning people that are going to understand a CBT paced program as opposed to your more young person that's experienced trauma that needs a connection with somebody and that's what they need. So I guess it's up to the service to be able to recognise the needs of that person (indistinct).

PROF KING: Yes, it's making sure the right people have the access to the right services. So – and have a choice about how they want to interact with those services.

MS OSMAN: Sorry.

PROF KING: Please.

MS OSMAN: Emma Osman with the RFDS. I work on the peer support community mental health program We've Got Your Back that Vanessa referenced earlier. I was a consumer, I lived up near Cameron Corner. Just touching on technology, as you said, NBN and internet capabilities. At the lower end of the spectrum, I looked at doing relaxation and mindfulness courses while I was there. I didn't actually have the data allowance and bandwidth to participate in those programs.

PROF KING: Yes.

MS OLSEN: You know, I was capped at 60GB per month, that was it, and that was to service myself, husband, business, workers, everyone.

PROF KING: Yes.

MS OLSEN: I know that is now expanding, they're coming a long way with that, but it is still very much a problem for people out there.

PROF KING: Yes.

MS OLSEN: Again, I agree that it is fantastic at the acute end that we do have services available, but I believe again that it takes that connection with a peer or an appropriate worker, or a nurse at the hospital to explain to someone what that looks like. Because you're dealing with also – I can only speak probably from my consumer experience as a person living out there. You've got a portion of the population that still really isn't actually that comfortable with technology. And so if you're saying to someone, "Come in and" – you know, you really need that trust and that relationship with a person on the ground to get them to come into a conference room and feel secure, and feel like it is an appropriate thing for them to be speaking to a clinician on a computer screen.

So again, like we've said that connection and that enabling and that linkage between – that human linkage between a consumer and a service is what I think is going to help technology work, yes.

MS McMANUS: And if it's that – if it's your GP that makes the referral, then there needs to be a clear navigator in that GP service that actually takes the next step.

PROF KING: Yes.

MS McMANUS: Because obviously your GP's not going to be funded to sit and do that. So your care navigator that is able to support the next steps.

DR NACHIAPPAN: If I can just add to that, since we've talked about funding and the lack of funding. We're all in this room because funding is one of the issues in mental health, and I think no matter how much money you throw at mental health services, it hasn't made the (indistinct) difference the last few decades. So I'll just thought I'd - - -

PROF KING: Yes.

DR NACHIAPPAN: - - - put some of my thoughts into this. In the first reform that you propose, I think workplaces need support, like for example, you've got a workplace rep for the union. I think we need workplace reps for mental health and welfare. You actually need an individual in a workplace who takes responsibility – for example, a lot of people say, "HR does that, don't they?" Well who trusts HR? People are frightened that they're going to get the sack if they go to HR. They say, "I've got a problem with my child or my dog." They don't say – that's the next one, (indistinct) the problem case.

So you really need, I think, like a coordinator or a person designated, responsible for mental health and wellbeing of the staff.

So the other comment I wanted to make was funding. General practices are funded by the click-clack Medicare rebate.

PROF KING: Yes.

DR NACHIAPPAN: Which is woefully – I want to say inadequate. I don't think that's the right term – mismatched for current times.

PROF KING: Yes.

DR NACHIAPPAN: Thirty years ago when Gough brought it out, people thought it was the best recipe in the world. But Gough's long gone, and Australia's changed, and he got the sack, despite being a popular prime minister, and (indistinct). To cut a long story short, instead of getting too much into politics, you need to fund general practices in a different manner. Not just click-clack Medicare. Perhaps fund them with paying the salary of a mental health staff member. Don't give them a fistful of cash, give them an employee. Tell them you can employ someone, the government will pay for it. So isn't that a different way of reinventing the wheel?

PROF KING: So there was actually a program that was doing that, which was funding mental health service in GP clinics.

DR NACHIAPPAN: Yes.

PROF KING: Which then got defunded.

DR NACHIAPPAN: Yes.

PROF KING: But any experience – is that the sort of thing that we need to actually do properly?

DR NACHIAPPAN: I've been in this town for a little while. So in that time, some of these programs have come and gone. That mental health nurse program was a good one, but there were not many mental health services in Broken Hill at the time.

PROF KING: Okay, yes, they didn't – yes.

DR NACHIAPPAN: So we did attract nurses who were interested in mental health, but if they didn't get a credential and get their pieces of paper, which was stamped by the regulator in time, that the money was lost, the opportunity lost, the jobs were gone. So Lifeline is the best example, I think, of having people who don't need paper qualifications, who can make a huge difference in society. The same can apply in general practice. You don't have to be a mental health (indistinct).

PROF KING: Yes.

DR NACHIAPPAN: You don't have to be a GP with special mental health skills. Someone who's interested in that area can work in that environment, in primary care.

MS HAYMAN: You're talking peer support. Peer support.

DR NACHIAPPAN: Sure.

PROF KING: Well it can be peer support. It wouldn't, as I understand what I was saying, it doesn't have to be a peer, also someone with lived experience, that's somebody who has the relevant – the relevant skills aren't necessarily a bit of paper.

DR NACHIAPPAN: Yes, yes. Relevant experience, relevant interest, relevant enthusiasm to make a difference. And some of the best people in mental health are not necessarily the ones with two or three PhDs or multiple masters programs. They're not. So they're people who are enthusiastic about contributing in that environment. A clinician, like the mental health team, and the hospital. They're not all psychologists, in fact, there are very few psychologists on the mental health team. So it can be a social worker, it can be an OT, it can be a nurse. It can be someone - - -

MS OLSEN: Graduate counsellor.

DR NACHIAPPAN: Yes, exactly. So I think we need to look outside the square, and Medicare click-clack isn't the answer with general practice. It needs to be a funded clinician position, and if you attract someone appropriate, why not? It will make a difference to communities (indistinct).

MS SANDERSON: So I'd like to just follow – Joan. I'd like to just follow on from that. Like part of what I'm doing that at the moment is advocating that counsellors can get the medical – be on the medical benefits scheme. And like I was telling the girls at Lifeline just recently, this is a little story. I saw on TV in Queensland how people were having trouble with - snakes were actually getting into their pool, and they were getting in there and they couldn't get out, and they were drowning. So they said to the people, just put a rope in the pool and attach it to something so the snakes can come in, and they can have a drink and then go out.

PROF KING: Yes.

MS SANDERSON: And that's what counsellors do. Like sometimes we're that rope that stops people from drowning. And you know, you were saying before about that gap. There's a huge gap. You know, we can't do what psychologists do, and we don't even – you know, we don't even pretend we do. But the role of a counsellor is very important.

Like in my private practice, I don't – I don't even have to advertise, and I'm – like I'm nearly full.

PROF KING: Yes.

MS SANDERSON: Like with people. And so like, you know, I'd like to think that I provide that rope so people can come in, and they don't end up with full blown psychosis or whatever, because you're dealing with things in the early stages. I'm working with kids, and you know, right through so you're actually – like getting them to tap into the richness they've already got in them, so they can actually find ways of coping with things.

And like, if we all try and have to be – you know, trying to work out how we're going to make a living doing – this should be something that's guaranteed. You know, for counsellors, our role is important, and counsellors are working right throughout Australia in so many professions, and they're recognised like that. And you know, I think sometimes psychologists – and this has come from psychologists have told me this – they feel threatened. But we've all got a place, you know, we've all got a role to do, and a counsellor's role is just as important as a psychologist's. And statistically, there is no evidence that says that going to a psychologist makes a person any better than somebody who's seeing a counsellor.

MS McMANUS: As a psychologist, I can say that I cannot understand why there's a Medicare rebate for psychologists, and not for counsellors. Like, and that's coming from a psychologist. I do not understand why that is.

MS SANDERSON: So and unless this changes, like you know, we – as I said to you before, we have got people dying, you know, taking their own lives because they can't get in to see people. Or when – sometimes when they go to the hospital, the things that people say to me is like, every time I go there, I see a different counsellor, and I myself, if I was going to the doctor and I had to see a different doctor every time, I would be – I don't think there's anybody in this room that would want to do that, but we're asking mental health patients to actually go and see a different person.

And like, I might see somebody one week and I'll just pick up on something so I'll write it down in a note, and then the next time they come, I'll take them back to revisit. But if you're just checking on notes from another person that's looked at them the week before, how can you tell what you've already heard from that person? I just think that we have to look at – you know, this is a huge void. And I'm not – you're saying that there's a lot of psychologists in Australia. Well I'm hearing from family members in South Australia and Victoria that they can't get in to see psychologists, there's such a waiting list, and in the meantime some of them will end up in mental health facilities because they just can't get the help. So, you know we need to take our

blinkers off and start looking at the reality, you know, that counsellors have a huge impact in the lives of people, you know, so - - -

PROF KING: So our recommendation - so I mentioned the missing middle before, so let me just run through what our idea is. So you've got the psychologists and just reminded me on that I was going to ask is there any community psychologist practices in Broken Hill, but I'll come back to that. You've got the psychologists who should be trained in a range of therapies, not just CBT which is formally the one they can do it, but you mentioned Dialectical Behavioral Therapy. There's a range of other - what is it? The one that's specifically for trauma, eye movement (indistinct) - - -

UNIDENTIFIED SPEAKERS: (Indistinct words).

PROF KING: Yes, thank you. I'm not a psychologist you can tell, but there are a range in the sense of often new therapies and yet our psychological workforce seems to be spending most of the time under MBS dealing with mild and moderate anxiety and depression. So our idea is to say, hang on, you've got this trained workforce, you've got a huge service gap for people who are subacute, they're not going to emergency yet, we want a workforce to keep them out of emergency, right let's take the psychologists and bang them down there. And whether that's done through Medicare or whether that's done through some other funding arrangement, they're meant to have the training to deal with these people, the clinical evaluations are that they can deal with the issues of more serious anxiety, depression, borderline personality, bipolar (indistinct) and help people stabilise (indistinct).

But of course that then leads to a service gap down here because, you know, you now need people to be able to deal with anxiety and depression. So one possibility - you know, there's a range of possibilities can fill that gap. One possibility that we didn't look at in our draft report is whether the counsellors have a role in there. Whether again it's something like counsellors working in GP practices. I have quite openly said - because we've heard from counsellors around Australia who've said "oh, just give us the Medicare provider number, let us go through Medicare" and the road will be paved with gold and life will be wonderful, and I say, one, I think that's unrealistic. I would be very surprised if the government is willing to have more people under the MBS and as the GPs can say even if you get MBS provider numbers you then tend to have (indistinct) caps put on as you see with Better Access, the psychological one.

So I'd really like to understand can - I think the first one is should go to (indistinct) but I'll ask it anyway, can counsellors help fill that gap for mild anxiety, depression in a sense before they need to see, you know, the more highly trained clinician? And secondly how should - you know, is MBS the only way that can be funded or are there alternative models that we should be looking at?

MR GOUGH: Stephen, if I could just - sorry.

PROF KING: Please.

MR GOUGH: Peter. Sorry. Having worked as a counsellor for many years prior to (indistinct), I find that most clinicians, psychologists, counsellors, will pick the (indistinct).

PROF KING: Yes, I know.

MR GOUGH: So why would anybody come to Broken Hill, this high levels of skills when they can get paid for doing easy work in the cities (indistinct) - - -

PROF KING: Yes, which is the psychologists aren't out here.

MR GOUGH: By easy work, I mean the typical "I've got my kids a bit anxious at school" - - -

PROF KING: Yes.

MR GOUGH: - - - or "I'm not getting enough sleep". I don't mean to denigrate that but we are dealing with trauma day in, day out, working our (indistinct) out.

PROF KING: Yes.

MR GOUGH: Getting paid the same. So I'm here as an older person now, because probably my time would be back a bit.

PROF KING: Yes.

MR GOUGH: Plus I like the outback.

PROF KING: Yes.

MR GOUGH: There's not many of us around. Now (Indistinct) is born and bred here. One of the GPs up there is born and bred here.

PROF KING: Yes.

MR GOUGH: So they love it as well, and the doctor over here as well. So what incentives, apart from an MBS, can bring people here?

PROF KING: Except we know the MBS doesn't bring people here.

MR GOUGH: Correct.

PROF KING: Which is why I wanted to ask are there any community psychology practices because if you look at the map, we've actually got the heat map of where the psychologists are and where Better Access - which is the psychologists program under MBS - where that's accessed in Australia.

MR GOUGH: If I can just tell a quick story? (Indistinct words) down in (indistinct), but my clinical (indistinct) was overworked. She was booked out three or four months in advance. So she put her fees in a country town, it's \$350 now, with \$128 rebate.

PROF KING: Madness.

MR GOUGH: Her list did not go down, and people just paid more.

MS McMANUS: And that (indistinct) - that's the target population then isn't it? (Indistinct words)

MR GOUGH: So why should she come out here and get less?

MS McMANUS: (Indistinct)

MR GOUGH: In a less challenging environment as it were with less trauma, less suicides - - -

PROF KING: So how do we answer that? So we've got the counsellors, but also I agree the psychologists they're all in Melbourne, Sydney, Brisbane - - -

MR GOUGH: I'm glad you asked. Okay. We in Maari Ma has a number of overseas doctors.

PROF KING: Yes.

MR GOUGH: Part of their registration in Australia they must do - I'm not sure of the exact numbers, a couple of years in the bush. Why doesn't that work the same for psychologists? Or nurses coming in from England or Asia or wherever. If you want to work in Australia and be a professional person as an Australian you must go to the bush, just like the doctors. Highly skilled doctors, you know I'm talking about, so we get the benefit of them for two years without (indistinct) where they develop their skills. But also some of them love it here.

PROF KING: Yes and stay.

MR GOUGH: And they stay. Our program down there is a lot of locums. I came out here as a provisional psychologist as a locum.

PROF KING: Yes.

MR GOUGH: And the said, "Would you like to stay?" I said, "Great".

PROF KING: Yes.

MR GOUGH: Those sorts of programs need to happen because it's a bit like wine tasting, try before you buy.

PROF KING: Yes.

MR GOUGH: Nobody is going to speculate and come out to Wilcannia or Menindee or Broken Hill just on a whim.

PROF KING: Yes.

MR GOUGH: They need to come out here and immerse themselves in the amazing culture, the amazing history of the place and go "oh, we might just stay a little bit longer". So I don't

think it's a financial benefit, although there will probably be that. I think it's an immersion and family that experiential thing that people especially overseas nurses, doctors and psychologists, anybody.

PROF KING: So I'm going to push you bit on this because you've gone into one of my favourite areas. Does it have to just be overseas? So if you were training as a doctor in Australia, a number of universities require that you do rural placements (indistinct words).

MR GOUGH: I'm glad you ask. My stepson is in his second year at University of Queensland doing medicine. So he's already got his hospitals, Blackwater and Rockhampton, I think.

PROF KING: Yes.

MR GOUGH: And two years. As a provisional psychologist, as an older person now, the whole world of psychology is designed for rich (indistinct) city people, because it's six years of training. The last two years of internship you don't get paid. So how can a middle aged person with families and houses afford to do this. So I was lucky I've got, you know, a very forgiving partner. So in this provisional period why not pay these people to come out and finish their internship. Just like they do with doctors. So pay it if you come out to the bush. So if you stay in the city well that's your (indistinct) but if you come past the divide, you will get paid and you will get all your supervision and your qualifications and hours provided for you, and for young people to be here for two years there's every chance that they're going to form relationships, sport, community ties and stay.

MS SMITH: Vanessa here. I was just going to say I think you touched on the idea that they - you know, they choose to stay in the city because it's not so demanding. So for some people that can be quite confronting and a bit scary about working with, you know, particular people. So I think having access to really good professional support. So people may choose not to come to this - sort of this because they don't have that sort of collegial relationship within their profession. So, you know, once there's a critical mass then, you know, they will come.

MR GOUGH: (Indistinct words) or their co-worker. Whereas the scales need to be tipped. So I mean there's a brain's trust in this room that I'm sure if there was a new clinician, counsellor, nurse, whatever, we'd go in behind them and support them, and could be in cheaper accommodation, could be a provision of - I know we get salary sacrificing out here for NGOs, but that professional support is vital and we've got plenty of professionals here.

MS SANDERSON: Can I just say - Joanie - like the RCAP have put out a lot of information in (indistinct) counsellors, and they're saying that 2.7 billion would deliver 4.5 billion dollars in savings. So the money that you would actually help to support counsellors working out in the small communities would actually save the money - save the government money, and like I'm sitting here listening and like I'm 71 years of age and it's not about money for me. It's making a difference in the lives of people, so you know if we don't take our rose coloured glasses off and start looking at the reality out here, like, in my practice I'm not just working with people who've got a small anxiety, I've been working with people right from the highest level of trauma right down, you know, and they're being helped, you know, and it's about making a difference in the lives of people. You know, it's not just a job, it's actually, you know, you make a difference in the lives of a family and you change the next five generations. You

know, and that's where I come from and, you know, there's all this theorising but we've got to face the reality that being able to provide people with the medical benefits scheme for counsellors would make a difference in the lives of families.

You know, I said to you before, it's not because I want to big note myself, but if somebody comes and they can't afford it that I'll work with them for nothing. I'm not going to turn people away because - - -

PROF KING: I think the conversation goes exactly what - you're saying it's just not money.

MS SANDERSON: Yes.

PROF KING: You almost need to try before you buy actually.

MS SANDERSON: I know, but I know we need to get people out hearing (indistinct) person, you know, while we're talking about this, how many people in this city are thinking about killing themselves today because they mightn't feel comfortable in going somewhere and getting help.

MR WHITE: Yes.

MS SANDERSON: You know, three in the last two weeks have died and that's three too many.

PROF KING: Yes.

MS SANDERSON: You know, how much longer are you going to have this policy and that policy and, you know, all these theorising. We've got to start doing something because people are dying, you know, families are being affected every single day by, you know, what's happening in their lives. This is real, this is stuff on the ground. You know?

MS SMITH: I think that's why we're all here.

MS SANDERSON: Yes, so, you know, need to just be, like, saying, well, you know, there's all these sort of politics in the city and there won't be any hope of doing that, but if the needs aren't being met by the people that are in that gap, then what do we have to do? Even in the cities, you know, but - - -

MR GOUGH: Get people here. You know, I think the problem you say - - -

PROF KING: Sorry.

MR GOUGH: Sorry, Peter. It's absolutely agreed, but we haven't got enough so how are we going to get more?

MS SANDERSON: Yes.

MR GOUGH: And just to throw on from that, and I might have spoken early to Steve about this, is that I look around the room and a fairly Indigenous population in the West, how many Indigenous counsellors are here? How many specific to male trauma are here? How many female traumas are here; trauma counsellors? Whereas, no disrespect to people here, we're probably on the older side than the younger side. How do we get young people to deal with our younger population? You know, it's got to be these incentives that, yes, there's money in NBS and all that. They're not turning up because each town they come to from Sydney, they're dropping off and they don't get here.

So we have to work out a way, through incentives, through even fast tracking some qualifications because they get their fair share there, to give people, just like the doctors we work with, if you're going to come to Australia, you've got to go bush. But that little - a big story about Pyramid Hill; the town died so they imported all of the workers that worked there in their pet food factory, and now it's the most prosperous, fastest growing town in Victoria because they had a structure where they took people, put them in the bush and they loved it.

PROF KING: A couple of people up the back wanted to - - -

MS OSMAN: I just want to touch on workforce retention.

PROF KING: Sorry; just again, name for the transcript.

MS OSMAN: Sorry. Emma (indistinct). Just wanted to touch on the UDRH the University Departments of Rural Health.

PROF KING: Yes.

MS OSMAN: It's supported throughout Australia, and that is that concept. Brings students out to a rural area and you have that served into - you know, you can take the fish so to speak - who will have the experience and they will come out and they will practice as clinicians.

You've also got the CUC - Country University Centres that are about people that are studying remotely, giving them a centre and the technology. They've got great internet connection there, they've have telecommunication, you know, video conferencing facilities, they've got tutors. I think that's really important is making it accessible and affordable for local workforce to upskill. So if you have a counsellor so, like you said, enable them to become a psychologist if they like, have the programs with the resources and then give the individual the financial means to continue their life and step-up into that role within their community if it's not actually enticing people to come out. So it's a double-sided thing. I think it's, yes, as you said, education and - - -

PROF KING: I totally agree.

MS OSMAN: Yes.

MR GOUGH: Just on that; University of Melbourne have got a rural health centre in Shepparton, one and a half hours from Melbourne.

PROF KING: Monash have in Mildura.

MR GOUGH: Like, we do a lot of work with universities from everywhere.

PROF KING: And on that last point, I did a pharmacy inquiry a few years ago, which was interesting. Pharmacy is an interesting area, some of the regulations there. But one of the interesting parts we went out to Wagga. We expected to hear from Wagga what we heard, you know, travelling around, we went out well and truly out bush; we went to Fitzroy Crossing and so covered a lot of Australia.

Pretty much everywhere out of the cities was we don't have enough pharmacists, you know, it's impossible to get pharmacists. We went to Wagga and said, 'Oh, I guess you've got a shortage of pharmacists.' 'No, we've got pharmacists coming out our ears.' 'Why?' and they said, 'Well, Charles Sturt University has a campus here and it's got the pharmacy school here.' Then they said, 'It's not going to last because they're about to move the pharmacy school to Bathurst' - well, Orange actually it might've been - and we expect that, you know, the numbers of staff will be dropping off.

But if you get people doing their training in the bush, a lot of them stay because, yes, you said, they make relationships, they, you know, learn actually it's really nice.

MR WHITE: Well, this is the thing about if you live in the city, you've got to spend two hours on the train going to work.

PROF KING: Yes.

MR WHITE: And I talk to a lot of people who've moved out here and they love it because they can get to work in eight minutes or they can walk in 15 minutes, you know, to work. But what people saying about getting them out here, for probably the last 15 or 20 years, M LC, Methodists Ladies College from out at Burwood, they've been bringing their girls out here. Right? They bring them out here and, like, they're 14, 15 years of age. They bring them out here and give them the taste of Broken Hill and I encourage them, when they come to our church on the Sunday, 'Thank you.' We get 30 or 40 girls.

PROF KING: Yes.

MR WHITE: 'Thank you, we would love you to come out when you become qualified doctors, nurses (indistinct), whatever you' - - -

PROF KING: Come back.

MR WHITE: 'Come back please, and fill our positions out here,' and I encourage these girls and they love it out here. You know, they stay out at (indistinct) where they wake up in the morning and there's four or five kangaroos at the door, you know, and they go, 'This is great out here.'

PROF KING: Yes.

MR WHITE: But we need to do this. I do an exercise class for the Wednesday morning which is operated by the Uniting and the young lady who does the class quite often turns up with a couple of extra girls who are actually out here for their training (indistinct) and they love it. They come out here and the go, 'Yes, we're fully qualified,' then they come back out like (indistinct).

MR GOUGH: Sorry; it's Peter. The problem with that is it's only six weeks.

MR WHITE: Yes.

MR GOUGH: So they don't immerse themselves.

MR WHITE: Yes.

MR GOUGH: It's good, but they don't live here and they might see clients once or twice and then (indistinct).

MR WHITE: Yes, that's right. But we need to have the, like I said, out here for the first two years. If it could be made so that they do this for the first two years of their training as part of their training. You know, and like you said, they'd make connections and I mean we had the guy who started Lifeline here moved here - Brian Nichols - moved here over 40 years ago and loved it that much here he moved. Admittedly he moved from Port Lincoln and didn't move from the city, but he moved out here and he could see that Lifeline was needed here, so went off to Sydney, and then he went overseas. He went over to New York or somewhere over there and it was - - -

PROF KING: Yes.

MS LATHAM: So I was a nursing student from Byron Bay (indistinct).

PROF KING: Sorry, can I get your name for the - - -

MS LATHAM: Vanessa; from RFDS. And so in 2009 I came out here as a university nursing student for five or six weeks through the Yooyah H Program and partnership with Southern Cross Uni. So that's sort of how I ended up back out here. So I've been here for eight years now and I'll probably stay forever. I don't want to leave; and I suppose I just had some other comment back on the mental health workforce with nursing, psychology, social work, counsellor. Like, while we all do different under grad discipline training or not even tertiary training, we all actually go off and do the same CBT Apt, DVT, complex trauma, PTSD, we do the same (indistinct) so that multidisciplinary team can actually provide a lot of the same services.

So I've been an advocate as a mental health nurse for Prudential Mental Health nurses and counsellors to either gathering work over the GP (indistinct) Care Plan or maybe as more directed towards some sort of block funding or something with the GP practices. But every GP practice should have some rural (indistinct) or mental health professionals.

Sometimes too with some of the psychology services, I've got staff in Dubbo, Cobar and Broken Hill and outreach. The psychology services we refer to, because they only have the limited sessions, they actually can't really delve into a lot of the trauma (indistinct) we need those block funding thing might be good that doesn't have a session limit and I have (indistinct) funded under (indistinct) which is that GP mental health nursing program, so it's through the PHN funding now. There's not much of it left though, that model, but it's got no session limits, so that's quite good.

And the only other point I just wanted to make which is sort of going back actually to technology, but it's the infrastructure. Like, we get a lot of different funding and if you go looking for it, there's a lot out there. But none of it generally is for buildings or infrastructure. So we don't have - just think of Telehealth. We've got 10 people in a tiny room. If you're on the phone to a client and then your colleagues are also on the phone and it's horrible. Like, we just get up and, you know, you just end up standing up somewhere in the car park or something and talking.

PROF KING: Yes.

MS LATHAM: I just think that's another thing, it's just a big point. There's a lot of funding for the service or the workforce, but you've got to have the buildings and the infrastructure as well as the transport logistics.

PROF KING: Yes, one of the things we had to do and I know (indistinct) is exactly that. The funding which you get for services doesn't actually cover the capital. So is that general experience?

MS LATHAM: Yes.

MS CROSSING: Can I just say something? It's Kayleen.

PROF KING: Yes.

MS CROSSING: So I've just recently started my job, a week into it, and we're still trying to find a social worker that, due to our funding, we've got lots of money sitting there but we can't use it because we'd need a social worker that needs to be qualified, you need this. We've probably had 10 to 15 applicants apply that, because they haven't got that degree. They've had (indistinct) 10, 20 years' experience living in Broken Hill, working in the community field, and because they haven't got that degree we can't - we've tried ringing up the funding body, 'Look, this is what we've got,' 'No, that's not good enough - that's not good enough.' Even though we've got a community person that's living in Broken Hill, that can't apply, they've applied and had to be declined.

PROF KING: So is that because it's written in the funding agreement for the relevant services that it has to be a social worker.

MS CROSSING: Yes, it has to be a social worker and we're trying. Like, the manager has been on the phone to the funding saying, 'Look, this is good getting all these applicants,' but because they've got - like, I'm diploma trained doing a degree. I was lucky enough (indistinct)

word) I've got a Diploma in Counselling so that qualified that funding to go to me. But that social worker - like, I'm working alone at the moment without any help from another worker because to get a qualified social worker that wants to come to Broken Hill or are already in - most social workers have got jobs in Broken Hill and that leaves some (indistinct) Yes, so as I said, I think there's been about 10 to 15 applicants we've had to decline or can't interview because they haven't got that degree.

PROF KING: Yes, so the funding is restricting, so it's basically input-based funding rather than outcome-based funding.

MS CROSSING: Like, we've got people that are 20 years' experience living in Broken Hill in the community field and we can't employ them.

PROF KING: I mean the gold standard for any services is outcome-based funding which, if you could do it - yes, you wouldn't say, well, you've got to have a social worker or you've got to have a psychologist or you've got to have a counsellor because you'd be measuring the outcomes.

MR GOUGH: Sorry, it's Peter. I think part of that is that organisations are risk adverse to people who are members of professional bodies (indistinct words).

PROF KING: They have a bit of paper, yes.

MR GOUGH: Yes, and they're very risk adverse to that.

MS McMANUS: And don't have something (indistinct) working ongoing.

MR GOUGH: Yes.

DR NACHIAPPAN: Ramu Nachiappan. It's a regulatory environment that Australia has become very good at. We're overregulated, but we're one of the most regulated countries in the world where a lot of organisations are top heavy administrative and the clinical services are just getting drier and drier and drier, and Broken Hill's the perfect example of that and where there is infrastructure, they are large structures, but the administration is such a big machination that the service provision disappears in that conglomerate.

Now, more graduates was supposed to mean more doctors and it hasn't happened. So there's been a tsunami of medical graduates in Australia from the days I went through (indistinct) Uni. I'm an 89 graduate, so I'm celebrating 30 years next week as a doctor.

PROF KING: Congratulations.

DR NACHIAPPAN: Thank you. So sorry I'm having to show off, and I've been here almost 30 years. So it is a grow of love for the environment. So more graduates doesn't mean more doctors. More graduates means more doctors queuing up in Sydney and Melbourne, Brisbane and Perth.

But doctors who are bonded, that's another experiment the government tried and failed miserably at because the bonded doctor has said, 'Oh, my girlfriend has gone to a different town. I won't go to the bush,' or, 'My dog's ill and I can't bring it to Broken Hill. There's not a good enough vet there.' All that type of stuff, so the bonding failed miserably.

So training in the bush; I agree. I had a medical student - and as Les pointed out, the MLC girls - she was out here 10 years ago and had such a good time as a MLC Year 10 student, she's come back as a final year medical student, spent a month with me here in the practice and (indistinct) university. So it does work but you see very few of them that do trickle through. It does work to a degree, but training in the bush is the key.

For example in Dubbo and the Monash Rural Medical School, the entire medical school training is in the bush. You can't just send them out for six weeks or 12 weeks. It's not enough. What Peter talked about; emersion. It's not enough and there's every year or two or three (indistinct)

PROF KING: Sorry?

MS COLE: Jo-Anne. I'd like to say Australia signed up as a - the government has signed up for international conventions on human rights and Indigenous rights. I think it's good to see so many kind hearted people and hard workers and the amount of people. But I think some people do have (indistinct) to care and I think, given our history and the social context, it's good that we have health and mental health as some sort of antidote, but I can't help but thinking a bit ironically about the social context that we all operate in and some of us are more well-mentally health speaking than others.

I'm a mental health system user. I had a friend who passed in the mental health system in Adelaide and hearing voices and then, was taken to the Broken Hill Hospital and sectioned - detained under the Mental Health Act.

PROF KING: Yes, compulsorily detained, yes.

MS COLE: And that was scary because I thought, well, (indistinct) start the symptoms were I thought (indistinct) human rights and Indigenous rights (indistinct) and just evidently my friend had passed after being in the mental health system in Adelaide and I was scared of getting sent back there and whatever.

PROF KING: Yes.

MS COLE: But also as a social construct, New South Wales and Broken Hill, to me as an Atjinuri woman, an Aboriginal from the Coorong in South Australia, sometimes what makes me laugh is this. New South Wales government would send me - when I was a very young girl - would send me a benefit with free transport in New South Wales and my homelands and waters are in South Australia and I'm like, okay, if I was well enough to travel and, you know, see my loved ones and, you know, have a natter and say, 'What's going on here?' it was a bit ironic that was the irony and I can - and before I got unwell I was studying a bit of politics and my BA and I had whatever. I didn't have my HSC, so I didn't have that background, but it's very interesting and I think everyone in Australia deserves human rights and Indigenous rights

and it makes me sad that I see, especially with people of mental illness, suffering in some way in those areas.

PROF KING: Thank you.

MR JONES: Just to follow up; it's happening even in the drought now, it's everywhere. Only when certain characters or, you know, how we identify people, farmers or whatever, we have (indistinct) professional ethics (indistinct) to drop or rise. You know what I mean? The standards of whoever walks through that door. What was your name again, sweetheart?

MS COLE: Jo-Anne Coles.

MR JONES: What Jo-Anne was saying - - -

MS COLE: Maxine Cole's daughter; you might know her.

MR JONES: I think we've got to sort of at professionals, stop that behaviour of leaving this mess that, you know, farmers (indistinct) so they must be doing all right. You know? Aboriginal people get that. You know? Their (indistinct) you know and we've got to have professional people are worthy - the human content - the human (indistinct) that go on and saying why couldn't they just see that person, you know, or their family, whatever.

MS COLE: Yes.

MR JONES: Not carry that all label them as a certain category of people or whatever, you know, or whether they live (indistinct) where they live down in wherever, you know. We have to stop that in professional people and that's - - -

MS HAYMAN: Well, that's what we're supposed to be doing. We're not supposed to - - -

MR JONES: Well, they don't matter. Look, the ethics have dropped. I know and so do people who go in with a tablet, there's another group (indistinct) head scan, you know, on a head injury. So we've got to work out better ways as individuals, let alone professionals, how we do that better, you know, and labelling people just on their parents or their culture or their location where they live, all these professions you know.

PROF KING: So that's a nice Segway into the broader - should I call it stigma or discrimination because I was using the term stigma, and someone said to me, 'Look, let's just call it discrimination because that's what it is,' and it seems to exist right across the mental health sector. So we know just from the status that if you've got a mental illness you may have physical illness as well. But your treatment of your physical illness will be different because of the mental illness. So in other words there's parts of the medical profession who say, 'Well, you're mentally ill, therefore, that's the cause of everything.' So I'm just (indistinct)

We know that there are institutionalised approaches that people (indistinct) stigma and discrimination. So for example if you've ever seen a counsellor or a psychologist try and get

income protection insurance and you'll find you can't. They just simply rule you out. It doesn't matter what you saw, whether it was 20 years ago, you get labelled for life.

You know, if you broke your leg, that wouldn't happen so why does it happen for mental ill-health. You mentioned sectioning.

MS COLE: We are very (indistinct).

PROF KING: And again, that's - I have some problems with this. Julie's not here. Julie's one of the other commissioners who is a lawyer and so we've had a few discussions about this, because I see that as just simply discriminatory because, unless you are a danger to someone else, you know, if you have a (indistinct) illness and you say, 'No, I'm not taking my medicine.' Let's say you're diagnosed with cancer and you say, 'Well, I don't believe in traditional medicine. I'm going to have an alternative medicine,' and the doctor says, 'No, no, that's going to kill you,' or your GP says, 'That's going to kill you,' and you say, 'No, I want to do this.' Well, nobody in physical health then says, 'Oh, well, we're going to stop you from doing that to protect yourself or your reputation,' or the other ways they can section you. I mean (indistinct).

MS McMANUS: But unless that's if you're of sound mind. So I guess if you had dementia and you were making poor choices about your treatment, then someone would override that as a duty of care. So I guess the Mental Health Act is to protect people who aren't of sound mind at that time who are making poor decisions who - - -

PROF KING: For themselves.

MS McMANUS: For themselves; who, when they're in a better state of mind, would not have made that decision and so, we're protecting people to get to that point where they're able to make better decision about their care and treatment, so it's very short-term.

I personally wish that the act could extend to drug and alcohol and I know it's something we haven't got; we won't fix in seven minutes, but we haven't talked about drug and alcohol today and it's - - -

PROF KING: Well, we can go more than seven minutes.

MS McMANUS: Okay.

PROF KING: Sorry.

MS McMANUS: Yes, and I think that the Mental Health Act does very well in the short-term management of people with mental illness and who are mentally disordered. I mostly have family members come to me asking the opposite; 'My mother needs to be in hospital; my sister needs to be in hospital,' and we say, 'The Mental Health Act can't be used for that. I'm sorry, we can't do that to help.' But I think with drug and alcohol, the system so poorly supports people who are intoxicated or have an addiction, who aren't in a position to be able to good decisions for themselves and I don't think that the current act - not the inebriate act - the

(indistinct) Act which is what it's called - doesn't serve the community and I think that we know that a lot of suicides occur - have (indistinct) more with drug and alcohol use.

So I guess that's one issue, as drug and alcohol in Broken Hill is an issue and I don't think that the mental health system protects people who are addicted or are disordered with drug and alcohol use.

PROF KING:

MS McMANUS: I'm going off track I know but - - -

PROF KING: No, and if people want to bring it back to broader issues of stigma, I'm very happy to but, yes, thank you for bringing that up because that is one I think we haven't touched on. So drug and alcohol comorbidities; what do we need to think about; what do we need to understand in regards to that in Broken Hill? To what degree is that a factor in suicide? If it is a factor in suicide, how do we deal with that problem?

MR GOUGH: Peter. We've had four suicides this week.

PROF KING: Yes.

MR GOUGH: I believe it's all male. That sort of rolls off the tongue a little bit for me and I don't think people really understand the gravity. It's a bit like the war dead; 1000, 2000, we lose the gravity, and it's four communities. That we would've had more representatives here that do have (indistinct).

The stigma - I deal a lot - across the board, but I've fallen into the men's' mental health - and these are all men. They're middle-aged men, typically coming from a very, very volatile abusive childhood where they've been either sexually or physically abused for a lot of their time. They get to the point where they drink too much, as we all know, and we're talking about significant amounts; four litres of wine plus a day.

Where I used to work up in the north coast, they used to inject methylated spirits, abhorrent ways to get anything into their system to make the trauma leave them and I think that the - and we spoke earlier about - I think the actual solutions are quite easy, but they're missing the mark.

PROF KING: Yes, do you want to expand?

MR GOUGH: And it's stigma; because real men don't cry. Now, we've heard that for a long time, but not to diffuse from other charities and things like the Pink Ribbon Foundation, Women's breast cancer, one of the organisations, and there's a (indistinct) breast care nurse in every town funded by the McGrath Foundation. Who's helping the blokes? We've got Beyond Blue with some ads, and that's great, but they're just ads.

Where is the funding out here for Beyond Blue? Who's going to fund Maari Ma or the Far West Local Health Service to just run men's programs and focus on trauma. Suicides come from trauma; they don't come from alcohol.

MS COLE: You know, they've got other Australians like the Stolen Generations. Like you can't get away from your history. It's (indistinct).

MR GOUGH: So we've got the Feeling program with Maari Ma which is focused on that conversation which is one of them. However, who's controlling and managing the trauma? Now, we all touch on it but disengage and all that but it's all because of stigma because men don't want to talk about sexual assault. You know, men don't want to talk about their fathers or their mothers or their mother's body or their father's or the deaths or the abandonment because it's too hard.

So it's probably, as all the clinicians know, it is the hardest of all psychological conditions to treat because there is no tablet. We have to get people relive their experiences to treat their experiences and, when we do that, people disengage because it's too grotesque for them (indistinct). So we're all pretty good at dealing with the peripheral of that. But to get somebody that will leap forward and say, 'I'm fixed,' is folly. It's not going to happen.

PROF KING: So how do we do that and it's not actually just an Indigenous but it is (indistinct words). recognise it in your own role. How do we - we've got a twin problem then of intergenerational trauma and stigma about things (indistinct) come before. How do we get around those twin problems?

MR GOUGH: It was interesting; because I spoke to a guy yesterday who was severely gang raped as a young male in one of the communities here and he's 40-odd.

PROF KING: Yes.

MR GOUGH: Now, wanting to lay charges, but he was suicidal two weeks ago. Now, the treatment wasn't actually treatment, it was counselling.

PROF KING: Yes.

MR GOUGH: It was sitting there, being there, believing and listening. True; we've all done some pretty serious training in this (indistinct) of stuff. But there's how many male counsellors in this room? No disrespect to the women, but blokes sometimes don't want to talk to women.

MS BEESTON: I agree.

PROF KING: Yes, and women sometimes want women counsellors.

MR GOUGH: And being a little bit grey haired and that sort of stuff. It's not a father figure, but it's a peer. So we've got lots for adolescence and kids; it's wonderful there is that sort of stuff, but who's talking to middle-aged men who are typically the ones killing themselves - typically.

DR NACHIAPPAN: A large majority of Australians visit their GP at least every year. So the general practice is recognised in Australia as perhaps the port of call for every Australian, before something like this happens. However, the way general practice is funded through Medicare, it doesn't allow the provision of services for the people who actually need

it. For example, in a bit like a 15-minute consult, it is not going to solve this issue.

PROF KING: So how do we create, maybe through a GP, but maybe the GP is the gateway into the effective services. How do we get the effective in community services? I mean, is it just a case that we just need - it is just a workforce issue, but until we get a workforce in, we're just, in a sense, wasting our time. That has to be done (indistinct).

DR NACHIAPPAN: (Indistinct) to be honest.

PROF KING: Yes, okay.

MR GOUGH: Because everybody's trained here, but they're far too engaged with somebody with some significant trauma. It's not for a six session Medicare plan. It could be two years. It could be five years. I've dealt with people for three years, and then just as I'm saying, look, I can't help you here, bang, there it is. Now we'll get into it. So it's funding the workforce, and if we look around the room, where are the male Indigenous counsellors? Not just peer counsellors, but trauma counsellors to, I suppose, take these people back from the brink.

Listen to them and say (indistinct) contracts and suicide contracts and things like that. Keep them alive. Because the longer they're alive, the more chance that they will stay alive.

PROF KING: Alive; yep.

MR GOUGH: Because I'm really - after many years in the police force, I've cut a lot of people down out of trees. We forget that each one of those people that dies is so valuable, and four in two weeks. And seriously, my people that I work with are expecting six more in the next two weeks.

PROF KING: How do we - - -

MR GOUGH: Which is horrific. It's proactive. We know it's going to happen, and we're just bracing for it to happen.

PROF KING: Would that also work with kids? So my background is - for various reasons, so for six years I was going back and forth between Melbourne and Perth, and so when the Kimberley cluster of deaths, the 12 plus one occurred, sort of a bit eye-opening for me. The Coroner's report there makes it very clear that these kids did not interact essentially with anyone, certainly no health services, before taking their own lives, and that was a terrible cluster. Male counselling. How do we help the kids?

MS BEESTON: Yes. Just a small point on that. I've been working in a high school in that counselling role, I probably dealt - and I'm talking only part-time and probably only over, like, a couple of years. I saw at least three or four children that had talked about suicide to someone, and they ended up in front of me.

PROF KING: Yes.

MS BEESTON: So, yes, I'm just saying that kids will open up to - to people. They have,

again, that connection with, that relationship with. Whether it's a teacher, whether it's a youth worker.

PROF KING: So it's only the schools - so GPs are fine for adults, but is it the school for kids that we should submit to parliament.

MS BEESTON: Look, I just think they've - - -

PROF KING: As the entry one, just casually.

MS BEESTON: Yes, I think, you know, certainly, you know, they come to us in the school when they're (indistinct) just someone that can help them further.

DR NACHIAPPAN: My feeling is to throw some light on that. I run a private practice. It's a (indistinct) practice. So the clientele I attract obviously exclude a lot of very vulnerable people. Teenagers are rarely seen because of that one-day a week now, I work for headspace, it's a better cost. Because I was losing the skills in managing cross-sections of society, because I don't get to see them. Now, generally speaking, people will take their pets to the vet, but their children to the doctor; maybe very young children, but the teenagers, we're not engaging with the teenage population. That's a big hole, I think, in society.

MS HAYMAN: It's Jane. But in saying that, kids, especially teenagers, are reluctant to talk to us as well.

DR NACHIAPPAN: There's that as well. Yes, that's true.

MS HAYMAN: Exactly.

DR NACHIAPPAN: It's a two-sided thing, so I don't want to take all the blame. It's two-sided. It's not just general practice or service providers. It's also the consumer. So how do we engage the people who need to be engaged? I think that's one of the biggest issues now in mental health in Australia. The people who need help are not seeking help. So ones who don't really need help, you know, your mild anxiety, depression. Nothing against that, but they're not on medications.

They're very good at coming to the GP asking for mental health plans, getting their six visits and four follow up visits. They're soaking up the funding that's being put out there. But the target population, we still don't know who they are. In fact, we only find that once they've suicided.

(Indistinct)

MR GOUGH: I've got one point and then I'll probably have to go, which is good so everyone else can get a turn. Where are the Indigenous counsellors? This local population is so rich and its emotional intelligence and connectivity with everybody. They're full of intelligence to do these courses, and we've got a great program there for Indigenous health workers. We need Indigenous psychologists, counsellors, OTs, everybody. But where do they train? It's very expensive to move to Wagga or Dubbo or Mildura training. But where do they train to do these

higher level, specific trauma, suicide prevention courses?

And that's probably where my solution, I think, is simple but hard, is it is funding and it is staffing. Because if you've got somebody that can relate to these kids, not an old bloke like me, but a young, you know, a really good young person in that school environment, they're going to have footy with them, they're going to have cricket with them. They're going to develop this rapport that will continue outside the school, and probably for the longevity of their teenager years, which gives them a go to.

MS McMANUS: I think the Aboriginal traineeship program at the mental (indistinct) and alcohol service is 50 per cent effective in retaining our staff who go onto become clinicians on our service, so Aboriginal clinicians. But again, and we keep talking about it, it's having the experienced staff around to support the training and supervision of those staff. So we've taken on a new - we get lots of applications for these positions, by the way, more than any other physician.

We've advertised for a psychologist three or four times; we've got nothing. But we advertised the Aboriginal traineeship and I think we got 12 applicants. So, the last round of the two positions (indistinct). But yes, it's about having the experienced staff around to support that program.

PROF KING: To be able to support the (indistinct).

MS McMANUS: And so next year, I think our community team couldn't support another trainee.

PROF KING: Now, we had a comment from the back end there.

MS PICKETT: So, I agree with Peter. It does actually come down to funding and money. Like, at the moment, the school counsellors, there's not even one school counsellor in every school now, where here a few years ago, there was. We're struggling to get counsellors out into the schools. So I think you need to look at why. Like, where's that attraction. Like, where's the packaging, and stuff like that. So then that puts stress on the services, so hence they probably (indistinct), because the schools can't support, yet we're meant to be funded for it. (Indistinct). Anyway, a men's counsellor.

PROF KING: Sorry, just before we go off that, also. So you had 11 applicants for two positions for Indigenous counsellors?

MS McMANUS: Yes.

PROF KING: Yes, wouldn't it be great if you actually had funding so you could - and the ability to support them.

MS McMANUS: To support them.

PROF KING: Train them, so you could say, yes, come on and explore a little.

MS McMANUS: Absolutely. The interest is there.

PROF KING: Yes, okay. Sorry.

MS PICKETT: You know, we've actually - we had - like, we get students come out to do placement at Lifeline and some of them are absolutely fantastic, but we can't retain them, because we don't have the funding to pick them up.

PROF KING: Yes.

MS PICKETT: We had a youth counsellor last year. Amazing. No, headspace in Adelaide have now got her because we weren't (indistinct) funding. Yes. At the moment, we've got an Indigenous student with us, haven't we? And she's fantastic, but there's no way she's going to stick around either. Yes, so it is. I hate to say it's about the money.

PROF KING: But it is about the money.

MS PICKETT: But it is about the money.

PROF KING: Yes.

MS PICKETT: Yes, and it is also about how - how we spend it. You know, you might get - we only get dribs and drabs of funding, but there's so many restrictions about how we'll do it. So, you know, it can't be vehicles or anything like that. We do a lot of outreach, so, but you know, you've got to have some way to get there.

MS SANDERSON: So can get a message through to whoever gives the funding that they should (indistinct). They should be giving it to Lifeline, when their core business is suicide prevention.

MS PICKETT: Yes. Like, Maxine's one of our counsellors. How long have you been a counsellor there? She was on the (indistinct) beforehand.

MS MAXINE: Ten years.

MS PICKETT: Ten years, and so the funding for Maxine - so she's on a casual basis, and it's just like a call in basis, but we get that through FACS.

PROF KING: Yes.

MS PICKETT: Which isn't enough.

PROF KING: Yes. The one that really resonates with me is you had 11 applications - no, no, sorry, this is - previously - in a previous life, I had this discussion all the time with the powers that be is that I would overemploy. I'd say, 'You don't have to worry. I'm in charge of the budget, you know, so yes, we only get two spaces available. Completely different sector. But I tell you what, we had five great applicants. I'm going to employ all five of them. But don't worry, because I'll still meet the budget.'

And if you get the right people in, you actually end up finding that they're savings elsewhere and, yes, it's unfortunate but we've got a system that is very much – we've got to fill the gap.

We've only got that position, we can only fill that position.

MS McMANUS: I should clarify that they were traineeship programs.

PROF KING: Yes, yes, no, I understand.

MS SMITH: I think – Vanessa, I think that's a really important thing is it's because it's the type of program that it is. So someone just has to have a passionate interest in pursuing that and they were actually afforded an opportunity to have the Bachelor's Degree at the end of three years. And three years of workplace training in the process.

So if we – I think - it's possibly a model that we could be looking at with other disciplines as well where people can actually be financially supported while they're doing their degree.

MS McMANUS: They can.

MS SMITH: And then, over three – they're more likely to stay back in that community, plus you're actually getting people who have – are born and bred in the community, who want to stay in the community and for any – you know, for other reasons would choose not to go to a capital city for training; they'll actually stay and be trained with (indistinct).

PROF KING: Des, and then I'm just going to very quickly ask if there's any huge issues that we've missed because otherwise we're not going to have time, so.

MR JONES: I was going to – just before Peter was going to leave, just a question. Do you think that this is the first time you've all seen the same room or? That's probably half the problem now.

MS PICKETT: We have great relationships.

MS McMANUS: Yes.

MS PICKETT: Where we have catch-ups once a month.

MR JONES: Right.

MS PICKETT: So that's health and RFDS and Lifeline, we're always having regular catch-ups and we welcome anyone that wants to join our - - -

MS McMANUS: And Mission Australia, I think, as well. And I know that health and (indistinct) have been building their relationships in (indistinct). So – but like, it was just said in our lunchbreak that we used to have our mental health interagency meeting and that stopped. But that's when we all used to come together in one room and talk about our services, and that hasn't happened for a while.

MS SANDERSON: Could I just say, Joanie, can I just say something on a lighter note? When we were talking about engaging teenagers, I find the best way that I engage with them is I take them out to Bells for a milkshake or a spider and we sit in the little side part and they just start talking. And I find that we've got a famous milk bar here, Bells, and it's at the South and kids love going there for a spider or a milkshake. And they just start (indistinct) and just start talking. So you just make that connection over, you know, over a cold drink and yes, so it's a good, yes. You know, that's what I find really helps me with young people.

MR WHITE: A cup of tea or coffee does the same thing.

MS SANDERSON: Well, I don't know if they'd be interested in that.

MR WHITE: I know, but that's with the adults.

MS SANDERSON: Yes.

MR WHITE: I mean, I visit quite often. My Sunday afternoons are taken up visiting – visiting. So I'll just pop in and see people that I know that either have been to church or have missed that day. And the first thing they ask is 'Would you like a cup of tea or coffee.' And I can understand why Ministers and people who do a lot of visiting put on a bit of weight, because the person they want to deal with, through a cup of tea or a cup of coffee.

PROF KING: Caffeine used to sort it out, too.

MR WHITE: Well, I can't have caffeine, so I've can't have coffee. But, well, neither tea or coffee. But yes, that's that thing. It's sitting down. And I've got to the stage now where even if I don't really need a cuppa, I have one because they – that's a good sharing time. Nothing like sitting around and having a meal with somebody to really share. And that's what saving lives is about, isn't it? Sharing.

MS OSMAN: And what is – sorry. Emma. This isn't in our capacity. It's as a community member. And it's touching on what Ramu said, identifying and how to access individuals in the community that don't even actually know they need to or want to access the service. And it's also touching on what Des said about supporting families and giving families tools to support people before they get to that acute stage.

It's just an observation about a family within the community that identified in someone that there's a big problem. They're reaching out. They need help. They need this person to have help. The person doesn't want help but the family's saying, 'What do I do? Do I just sit back until he breaks the law and the police detain him? Where do we go with this?' And so, you know, we may not be able to – what do we do in supporting those families? Because I think there is a lot of families in Broken Hill that are perhaps experiencing that. And it's – as I said, it's not – I don't know what the answer is. It's just an observation that is part of that link, is – is, yes, that family unit.

MS McMANUS: And it's, look, you're looking at those – it's not an early intervention because this person's identified, but it's – some services sort of say, 'Well, look, they've got

to come in. They've got to ask for help.' But you know, where Joanie's talking about and Peter's talking about having a male that might go out and just build a relationship and not try and do anything else, but just build that relationship.

MR GOUGH: Can I just add – sorry - to Emma's points. Sorry, it's Peter. I thought I was going to shut up. Not long after I got here, I got pulled into the police station because an Indigenous guy who was high on Ice did a car-jack. And they just needed somebody to (indistinct) with his things. And his sister was there, middle 30's and she was just so happy because he's now going to gaol and he can now get off the Ice and the grog.

PROF KING: Hopefully.

MR GOUGH: In gaol, yes. So gaol out here for Indigenous men is viewed as a good thing.

DR NACHIAPPAN: A therapeutic stage.

MS PICKETT: I've probably not heard that before.

MR GOUGH: It's a therapeutic time where they get fed, dental, all of that sort of stuff. I don't know what Des's experience will be on that? I'd love to hear it.

PROF KING: I'd love to hear it as well.

MR GOUGH: I don't know if Des would share that? But certainly the males that I see here, life's getting too hard, so I'll just drive in front of the police station, beep the horn and I'll go to gaol for not having a license. And that – I thought that was a bit of a myth, even when I was a policeman. But it is so not. For every (indistinct) so, I'm doing (indistinct) so I just need to go back to gaol for a while.

DR NACHIAPPAN: It is very true in this community. I was the sole provider with medical services at the local gaol almost three years. Many, unfortunately, Aboriginal males see that as their health farm, if you like. To be incarcerated. And to go back in again for incarceration to improve their health. Now, that's really a terrible state of affairs.

Especially for (indistinct) , isn't it. But that's known, that's the truth in Broken Hill.

MS SMITH: So that's really a crime, yes.

DR NACHIAPPAN: So that's very much exactly what happens. They come in, they say, 'I've lost my glasses.' 'Get my eyes tested.' 'Get my teeth fixed.' And 'Doctor, is my blood pressure going all right?' 'Should I go and see a specialist?' And I say, 'Why didn't you do this when you were outside?' And they say, 'I haven't got time for that.' Break in – break into too many cars or just – just doing that, just living their lives. And it's a terrible state of affairs that people have to commit a crime and incarcerate themselves in order to improve their health including their mental health.

PROF KING: Well, hang on, so – okay. So that's where I want to jump in. When you say improving their mental health, so the services, the mental health services in the prisons at least

the ones we're aware of but I'm not aware of what the local prison here. But the ones that we've looked at, the mental health services are pretty much non-existent.

DR NACHIAPPAN: Average.

PROF KING: Well, prisoners aren't allowed to claim the standard Medicare type of approaches so I'll give you a simple example. So – and, what about this one, another area I've looked at: Bandyup Women's Prison, which is over in Western Australia and ridiculously overcrowded, so when we were looking at it, it was approximately, I think it was built for something like 300 women. It had close to 600. So they just double-bedded every cell which led to problems in the cells. So massively overcrowded.

Their only mental health services were a psychiatrist for half a day every fortnight. So completely inadequate for the population. The prison superintendent estimated it was somewhere around two-thirds of the women in that prison had mental health issues. So whilst hearing that, yes, so for some people they see gaol as, in a sense, an alternative to being in the community which is a terrible thing. I also can't imagine – I can only imagine that they get worse by being in prison and that may just reflect my background in the prisons that I'm aware of.

So I think I want to make sure that I'm not bringing up my bias to –

MR GOUGH: I don't think it's for mental health.

PROF KING: No, okay.

MR GOUGH: They're going there for – because we're talking about some communities where we are talking third world abject poverty here, so they're getting fed, they're getting their clothes washed. That's what they're going there for because it – and a lot of their unfortunate relatives are in there. So it's like a – not a catch-up, but they're safe there. They're protected there.

MR JONES: Yes. And they don't need to think about what they do, do they.

MR GOUGH: It's - as Dr Brown said, it's a safe place. It's not about mental health. It's about – it's actually, and that's probably – we're running out of time - but it's about detox. It's about rehabilitation.

MS McMANUS: Yes, it's a (indistinct) state of also stopping drug and alcohol use for three months.

MR GOUGH: Yes. And they know that, 'I've got to get off so I'll go to gaol.'

MR JONES: No, even then, we've got to be careful we don't accept that as a - - -

MR GOUGH: Yes.

PROF KING: Yes.

MR JONES: - - - that we don't accept that as a pathway, because the majority that I speak to, like, they really - they don't want to go to gaol. Right? The courts just - the court system deals - that's the hand they're dealt through the court system based on whatever happens.

And I think Stephen, it's about - they get some respite in there, sadly. But it's when they're released, they don't get the follow up from when they're released back into the - in the population, back into the community again. So that's where we need to pick up, you know?

PROF KING: So let me follow up on that. So let's say it is drug and alcohol and they've gone with it, yes, okay, so they've gone dry which means that you have better protections in prison here - - -

MR JONES: Well, you don't - a lot of people are going to gaol, too. I mean, there's one a week that dies in gaol, you know?

MR GOUGH: The WA Prisons had a real drug problem in the prisons when we investigated them. I mean, it was - - -

MR JONES: They (indistinct) go, so let's - let's be careful and make it a safe place because a lot of people do die in gaol. We don't hear about it because it's all via a cop house where you've confidential information for the families. But I need some follow on stuff.

I mean, you know, medicinals are a restraining process that goes on as well, you know? Here they just give them tablets to quiet them down and that's it, so. So we need to be careful of how we look at all that, you know, that incarceration-type - you know, well, some people call it respite or whatever - but it's not. It's actually - I wouldn't like to be locked up with anyone.

PROF KING: No.

MR JONES: With a bunch of murderers and criminals and fearing for your life. But so we need to be mindful that when they come out though, it's - and when they're needing the support and the engagement again, to - - -

PROF KING: So the problem is there's no one to do that?

MR JONES: No.

PROF KING: Yes, I was about to ask. So there is no support at the moment for people coming out of there?

MR JONES: No, I mean, may the Lord save you, but if you're released out on the 21st, like tonight, 29th or the 28th, if you're released out on the 28th at 12.01 pm, you know, well, that's the end of the 28th.

PROF KING: Yes.

MR JONES: So you're released out in the darkness and if there's no one there to pick you up, you're on your own. So basically you (indistinct) later (indistinct) again, because you might - you might not have anywhere to stay. So all those things are going to deflate.

But I think, it's about – it's about – an eye to let that – the upfront stuff, you know, that – all the backend stuff, a lot of sense of design to deliver that, you know? After the fact, (indistinct) happened, well, everyone – but it's all preventable stuff we can do up front that I'd like to see.

You know, there's an investment in those proper non-committal approaches. And, look, right across Australia, we said we'd have a program called mini-development employment program. So that was sort of like Work for the Dole programs, you know, there – there was no employment. It kept a lot of people occupied, a lot of kids were going to school, people were valued, they got paid for what they'd done and there was some sort of contribution to the community. So when they closed that program, we saw all the spikes in domestic violence and what not.

PROF KING: Can I ask you why they closed that program?

MR JONES: Just a political decision based on Australia's community saying it doesn't work.

MS SANDERSON: Jeoff Hardy was in at the time.

MR GOUGH: No, it's lack of funding. It's like, I - - -

MR JONES: No, it actually was a million – a multi-billion dollar program. And they just closed it down over night.

MR GOUGH: (Indistinct) lack of funding for (indistinct).

PROF KING: So was it a lack of funding or was it a view that - - -

MR JONES: So it was a politically decision.

PROF KING: - - - it was a discriminatory program because to receive the relevant benefits, Indigenous Australians had to do different things to non-Indigenous Australians.

MS SANDERSON: No, because it was for the general community.

PROF KING: For the general community. Okay. Yes.

MR JONES: I mean anyone – anyone who's unemployed in our communities - - -

PROF KING: - - - was able to access it.

MR JONES: (Indistinct).

PROF KING: Okay. Just wanted to clarify that.

MS SANDERSON: Could I just share something? Up at Jamendi earlier this year, they had a music festival and the police and the Indigenous community worked together and during that evening there were a few things, where you could hear yelling and stuff. And as soon as that happened the police stood back and the Indigenous men just went around and got around this person and they just calmed them down.

Took them for a little walk and then brought them back in. And like, when you're talking about people coming out of gaol, that's what people need to do - gather around them. Because I - it was beautiful just watching this. Just seeing them just gather around, there was no raised voices and they were just, you know, helping them self-regulate by just being there with them. And that's what we need.

It's like there's all this stuff - it's easier to put somebody in gaol. But it's so much harder to actually have a program where you can actually walk alongside these people when they come out and then get them into, you know, perhaps Indigenous programs where they can be learning about their mental health and, you know, and if you're there just being there with them, they're more open to receive what people are trying to give them after.

But that was such an impactful night for me, just seeing that, you know? They were just - it was almost like this silent little brigade went in and just you know, put this safe haven around them.

PROF KING: Yes.

MS SANDERSON: And I think that's what we've got to do with people that are struggling with mental health. You know, it's like just making sure that there are programs there that you can just, yeah.

MS McMANUS: And I think the whole music festival in itself is a whole other example of lifting the community spirits.

MS SANDERSON: Yes, it was beautiful. Yes.

MS McMANUS: And another early intervention program that we don't always recognise the benefits on mental health in a community, just by having those sorts of events. But you're not going to get funded to run a music event.

MS SANDERSON: No, no.

MS McMANUS: But I do a lot of program.

MS SANDERSON: But I think it's - but because of the loss of the River and all that - - -

UNIDENTIFIED SPEAKER: (Indistinct words).

MS McMANUS: I've got some money that I could kind of (indistinct).

MS SANDERSON: But see, but again, that's so simple a solution, you know, it's like being - connecting with people. It's about that connection, and even if you're not, you know - - -

PROF KING: It's creating a sense of community and, yes.

MS SANDERSON: Yes, and it's – it's that connection that they feel when they come out that - - -

MS McMANUS: Sorry, we do have a community restorative centre, just and that's for supporting people who are released from prison to reintegrate. I don't know how long that that support lasts but it does exist.

MR JONES: In exchange that there's actually focus more on in prison now than out.

MS McMANUS: Okay.

MR JONES: And so which is a bit (indistinct).

MS LATHAM: We have – we have Caitlyn and a few other people who are mainly our drug and alcohol and communication therapists who sit in that building sometimes and (indistinct). But there's a group writing (indistinct) we have at the moment. And they meet people wherever they want really, around the town to (indistinct).

PROF KING: Okay. Just noting the time, are there any issues that we haven't touched on today that people really think we need to touch on that – remember this is the mental health inquiry. We have strayed a little bit past it, but you'll recognise pretty quickly that – yes?

MS HAYMAN: Yes, I think for younger men around twenties early thirties.

PROF KING: Yes.

MS HAYMAN: Neami run a program where they can actually go in and stay for a few weeks to get off the drugs and that. But they have no thing here that actually helps younger men with their mental health problem. I know a person, he obviously had a drug problem. But he also had extreme mental illness and he was, because of the drugs, he also had psychosis. Now, he couldn't stay at Neami until it was proved that he didn't have his drug problem. But he was released before they dealt with his mental health problem.

PROF KING: Okay.

MS HAYMAN: And he was in a really bad place for a very long time. There's – it's a big gap. You cannot get help for these younger men. Or these men in this age gap. The sort of - Headspace will deal with them only until they're 25, and after that they release them into the wild and they've got to look after themselves.

PROF KING: So the program is Neami, I think?

MS HAYMAN: Yes.

PROF KING: Yes, so it's a drug and alcohol program?

MS HAYMAN: Which is – it's a (indistinct) business.

MS LATHAM: It's a bit like an (indistinct) that manage a team bed sub-unit in - - -

PROF KING: Yes, we have them here.

MS LATHAM: So, yes, so – but they're actually – they're New South Wales help beds, and Neami run the program, (indistinct) can be placed in non-criminal's peer support. We added a (indistinct) support and health service, so it's a funded mental health program.

It has over time, taken people with drug and alcohol issues because they can have all those other mental health issues underlying that. But they need to be able to not be using substances while they're there, because it's not deemed that the program's suitable for them at that time. So I suppose that gets into what other services are available for people with drug and alcohol issues. And that's why we have services, which are pretty lacking.

MS HAYMAN: Yes, very lacking. And to follow up health. There was none once he left. And I think he was visited once by the team members that go out in the community and that was it and then he was just left to it. And no doubt he went downhill again really, really quickly. He just went back to his old ways, same mental health problems.

PROF KING: Okay. So the trouble – is the trouble the Neami drug program, then the intensive for a few weeks but then there isn't the supporting - - -

MS HAYMAN: Yes, yes.

PROF KING: Okay.

MS HAYMAN: There definitely needs to be something that fills that gap. Because these are probably also the younger men that are actually going out and killing themselves.

PROF KING: Yes.

MS HAYMAN: Because they've got (indistinct) or they don't feel like - stigma, once again they don't feel like they can go and visit a doctor or - yes, and they just seem to be lost. That's very lacking in this town.

MS PICKETT: So I think in that instance like there probably needs to be communication between services like, you know, is it possible for like, you know, Neami to contact us and say, you know, like a handover to another counsellor or something like that or - - -

MS HINTON: They do do that. There are times when they have a collaborative party which - as an exit, and I've actually participated in a couple of those.

MS PICKETT: So maybe that's just not happening enough.

MS McMANUS: Yes, it's got some peer positions and it's got, yes, but, you know, they are usually very good - - -

MS PICKETT: Yes.

MS McMANUS: - - - at talking with the consumer at discharge about what services the consumer might be interested in engaging with and sometimes that's - - -

MS SMITH: And (indistinct) engaging those services while they're (indistinct) so you've got that - - -

UNIDENTIFIED SPEAKERS: (Indistinct words).

MS McMANUS: (Indistinct words), has done.

MS HINTON: So when - Jan, again. When he left this service he was good, he was clean, his mental health was a lot better, and I guess they thought, okay, well you're good, you're leaving here in a positive way. Well that lasted for a few days until he went and seen his mate and - yes.

PROF KING: Yes and - which also, when we go back to a prison situation, we know that you're released from prison and you don't have the support services in the community, so who do you catch up with? Well you catch up with your mates, and guess what they're the guys who got you into trouble in the first place.

UNIDENTIFIED SPEAKER: Nothing has changed.

PROF KING: (Indistinct words), yes.

DR NACHIAPPAN: They've spiralled down (indistinct words).

PROF KING: Yes. Yes.

MR JONES: You don't have to come out of prison to get that, it can happen to anybody, you know?

PROF KING: That's true, yes.

MR JONES: You don't know what trigger will trigger somebody that you thinks all doing well (indistinct words), you know? It's happened.

PROF KING: Other big issues?

MS OSMAN: I want to just touch on drought and drought mental funding.

PROF KING: Yes. Yes.

MS OSMAN: At the moment - I can't comment on the funding that's available at the moment but from my perspective, you know, the health (indistinct) got new drought funding. It seems as services - yes, honestly I can't comment on that, I only comment as a consumer previously just within a service is that - and as a consumer if it doesn't rain (indistinct words) money and a quick fix deal then the business relationships and dynamics. So that's just my observation is to know that drought funding for mental health is a very - it's a long term fix, even once the drought has broken. The impact that this period of time has on business, on family dynamics on individuals is something that's going to need funding and programs in the long term.

So I just want that noted as an observation because I know that often when there is a crisis of some sort you get adequate funding but then the fall out that the fundings not there to build again after the incident. So it's just a notation.

PROF KING: All right. I'll draw it to a close at this stage.

MR JONES: Stephen, just one quick - - -

PROF KING: Please.

MR JONES: In the commissioning process of services, there's got to be a component where - whoever get the - whoever the successful tender is they must engage with the other services, you know?

PROF KING: Yes.

MR JONES: As part of that whole commissioning.

PROF KING: Yes, there has to be a way to coordinate.

MR JONES: Yes.

PROF KING: And services working together.

MR JONES: That's right.

PROF KING: Want to make sure that people - - -

MR JONES: If I'm going to receive money off a certain program I should be in that, I should be talking to who's relevant or - you know?

PROF KING: Yes.

MR JONES: As part of the contract, you know?

UNIDENTIFIED SPEAKER: Absolutely. It should be part of the (indistinct words).

MR JONES: It should, yes, it (indistinct words).

PROF KING: There also has to be funding for that because governments are very good at saying, well, we want you to do all these extra things but you're getting the same funding as before.

MR JONES: Yes.

PROF KING: And as you've said (indistinct words)

MR JONES: (Indistinct words), yes, that's it (indistinct words), yes, exactly.

PROF KING: Okay. Thank you very much. Thank you to everyone today. Thank you for those who have spoken to us. I've found that very helpful. Thank you for those who have also just joined us as observers. There are lots of muffins. Please feel free to take muffins, so - - -

UNIDENTIFIED SPEAKER: Well, I could take some back to feed the workers?

PROF KING: Please do. Yes, take a box. And formally I will adjourn until 9 o'clock on Monday 2 December.

**MATTER ADJOURNED UNTIL
MONDAY 2 DECEMBER 2019**