



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

MS JULIE ABRAMSON, COMMISSIONER
PROF HARVEY WHITEFORD, ASSOCIATE COMMISSIONER

TRANSCRIPT OF PROCEEDINGS

**AT LAUNCESTON CONFERENCE CENTRE, 50 GLEN DHU STREET,
LAUNCESTON
ON MONDAY 09 DECEMBER 2019**

INDEX

	<u>Page</u>
SLEEP HEALTH FOUNDATION PROF DOROTHY BRUCK DR GEMMA PAECH	4-12
AUSTRALIAN PSYCHOLOGICAL SOCIETY ROS KNIGHT	12-20
PSYCHOLOGY CAFFE TRACEY MARTIN-COLE	21-28
PIPPA ROSS	28-34
BALANCING OF LIFE COUNSELLORS JANE OAKLEY-LOHM	34-38
DIANA KUBE	38-40
DAVID ASTEN	40-44
TASMANIAN LIFE COUNSELLING SALLY JONES AND DAVID JONES	44-50
AUSTRALIAN COLLEGE OF MENTAL HEALTH NURSES MICHAEL BLAIR	50-54
MENTAL HEALTH COUNCIL OF TASMANIA CONNIE DIGOLIS	54-61
PSYCHOTHERAPY AND COUNSELLING FEDERATION OF AUSTRALIA MARIA BRETT	61-69

CARING FAIRLY ADELE BEASLEY	70-75
MENTAL HEALTH FAMILIES AND FRIENDS TASMANIA MAXINE GRIFFITHS AM	75-81
ROYAL FLYING DOCTOR SERVICE TASMANIA JOHN KIRWAN NICOLE GROSE	82-89
VICTIMS OF PSYCHIATRISTS INITIALLY NO	89-93
ABOLISH PSYCHIATRY PARTY GLENN FLOYD	93-97

MS ABRAMSON: Thank you. Well, good morning, everyone. Welcome to our public hearings into our draft report for improving mental health in Australia. My name is Julie Abramson. I'm one of the Commissioners on this inquiry. My fellow Commissioner here with me today is Harvey Whiteford. Before we begin today's proceedings, I'd like to acknowledge the Palawa people who are the traditional custodians of this land on which we are meeting, and pay respect to their Elders past, present, and emerging. I extend this respect to all Aboriginal and Torres Strait Islander people in attendance today.

The purpose of this round of hearings is to facilitate public scrutiny of the Commission's work, and to receive comments and feedback on the draft report. This hearing in Launceston is one of many around Australia, in all states and territories, in both capital cities and regional areas. We will then be working towards completing a final report to government in May, having considered all the evidence presented at the hearings and in submissions, as well as other informal discussions.

Submissions and comments to the Inquiry will close on 23 January, and then it will need to be publicly released 25 days after tabling in Parliament, which I think makes it August next year. We like to conduct our hearings in a reasonably informal manner, but I would like to remind participants that there are clear structures in our legislation for how these hearings are legally backed, and a full transcript is being taken. For this reason, comments from the floor cannot be taken. The transcript taken today will be made available to participants, and will be available from the Commission's website following the hearings. Submissions are also available on the website.

Participants are not required to take an oath, but they should be truthful in their remarks. Participants are welcome to comment on the issues raised in other submissions. I also ask participants to ensure their remarks are not defamatory of other parties. You are all free to enter and exit the room as you want, and if anyone needs a quiet space, please feel free to exit the hearing. If at any time you feel distressed, please approach one of our staff who will assist you, and our staff are just sitting over there. Ros and Lisa.

In the unlikely event of an emergency requiring the evacuation of this building, please follow the exit signs to the corner carpark at Thistle and Glen Dhu Streets, unless given an alternate assembly location by fire wardens. So, what we'll also do is we will have a little bit of time at the end of the day, so we are happy to take additional submittees at that time.

But if I could open by asking Dr Professor Dorothy Bruck; if you would like to commence, and if you'd like to read a short opening statement, that would be great.

PROF BRUCK: Okay. Thank you. Thank you, Julie. Welcome, hello Harvey. Yes.

MS ABRAMSON: If you could just announce who you are and where you're from. Thank you.

PROF BRUCK: My name's Dorothy Bruck. I'm speaking here in my capacity as Chair of the Sleep Health Foundation, a national not-for-profit organisation. I am an Emeritus Professor at Victoria University, with over 30 years' experience as an academic researcher and psychologist, specialising in various aspects of sleep-wake behaviour and sleep disorders.

This inquiry into mental health has already heard a number of presentations arguing it is critically important to consider sleep health in any review about improving the mental health of Australians. In short, there is a strong evidence-base that ongoing inadequate sleep and untreated sleep disorders are very likely to, firstly, increase the risk of subsequent mental illness; secondly, exacerbate mental illness symptoms; thirdly, decrease mental health treatment effectiveness; and fourthly, decrease mental health remission rates and remission durations.

So the first point is a question. If sleep is so important to help mental health, why not just use sleeping tablets? Sedatives are normally recommended only as a short-term solution within the medical profession; normally three weeks' use for an acute presentation. Problems with sedatives include addiction, tolerance, increased rate of falls, especially in the elderly, unrefreshing sleep, side-effects, interactions with other medications, and daytime hangover effects.

Studies show that people in the community are aware of the limitations of sleeping tablets, and are often wary of using them. The problems with sleeping medication exist where the sedatives are prescribed for insomnia that is comorbid or not comorbid with mental illness, such as depression, anxiety, schizophrenia, or post-traumatic stress disorder. There's conflicting evidence about the benefit of SSRIs for sleeping problems in those with depression, anxiety, or PTSD, and large individual variations in responses exist.

Sleep problems often remain, even for those with good daytime response to SSRIs. In some cases, SSRIs can be a useful adjunct to behavioural therapies for poor sleep. Over the last two to three decades, we've developed some highly effective and low-cost, non-pharmacological treatment options to improve insomnia, and this is specifically Cognitive Behavioural Therapy for Insomnia, known as CBT-I, different from normal Cognitive Behavioural Therapy. It's specific to insomnia, and also sleep apnoea, notably Continuous Positive Airway Pressure, known as CPAP.

With regard to the treatment of insomnia, many academic studies have demonstrated that CBT-I is more effective than sleeping medication in the medium and long-term. In addition, behavioural interventions that improve sleep have been demonstrated to have a large effect in reducing mental illness, such as depression and parasomnias, like nightmares, as may be seen in PTSD.

So my second point is that Australia has a big sleep healthcare gap. We know that there's a big gap between the extent of sleep problems and disorders in the community, and the delivery of effective diagnosis and treatment. We argue that this sleep healthcare gap contributes directly to the high rate of mental illness in Australia. The sleep healthcare gap, and its implications, have been well set out in the parliamentary inquiry report into sleep health awareness, entitled 'Bedtime Reading'. It was tabled in April 2019. We ask that this Inquiry endorses the relevant recommendations from that Bedtime Reading report. I propose to have a bit of a solution focus, I'm hoping, this morning.

MS ABRAMSON: That would be most welcome.

PROF BRUCK: In my written handout, that I believe you have on the laptops, we focus on solutions, and what I've done there is I've presented a series of tables. I start with a short summary of the economic costs of inadequate sleep, and juxtapose those with economic costs of mental health, and I also include some prevalence data. And the main tables below that takes the first three reform areas in your draft report, your overview, and adapts them, suggesting possible reforms to help Australia's sleep health.

The rationale is that we can improve mental health through the evidence-based, bidirectional relationships that exist with sleep health. So I welcome your questions and comments.

MS ABRAMSON: Thank you. I think we're also just dialling in your colleague, Dr Gemma Paech, by phone. I'm looking at Lisa. Yes. Thank you. Yes. On mobile. Gemma, did you want to add anything to the opening statement by Professor Bruck?

PROF BRUCK: She had her own opening statement.

DR PAECH: Yes, I've got some additional comments to make, just to support what Dorothy has already said.

MS ABRAMSON: Thank you.

DR PAECH: Okay. So I just want to start by saying thanks for the opportunity to talk to the Commission, and for the Commission in looking into a very important topic to a lot of Australians. Throughout this Commission, you would have already heard from a number of individuals and our sister organisation, Australian Sleep Association, about the importance and the bidirectionality of sleep and mental health.

So I'm not really going to go into more detail about that, other than to say that a lot of the times while disrupted sleep is listed as one of the main symptoms of mental health illnesses, disrupted and poor sleep can also lead to the development, as we're seeing, of mental health illnesses. In my opening statement, I would just like to highlight or focus more on how circadian disruption and circadian misalignment can lead to the development and an exacerbation of mental health illnesses, particularly depression and anxiety. So circadian disturbances - - -

MS ABRAMSON: Dr Paech, could I just - sorry, Gemma. Just a moment.

DR PAECH: Yes.

MS ABRAMSON: Dr Paech, could I just stop you there. Because it's a bit difficult with the phone, I didn't get the name of the disorder that you mentioned.

DR PAECH: Sorry. Circadian disruption.

PROF BRUCK: Circadian.

MS ABRAMSON: Circadian.

PROF BRUCK: Yes. Circadian disruption.

MS ABRAMSON: Yes, thank you.

DR PAECH: So this basically refers to a lack of alignment between the internal body clock, your circadian centre, and the external environment, such as a shift schedule or someone's sleep-wake patterns. And circadian disruption is something that's very commonly observed in a lot of shiftworkers and people that work around the clock. Circadian disruption alone can lead to increased risk of developing mental health illness, particularly in vulnerable individuals.

So there is people who already may have a predisposition, such as a family history or a history of mental health illnesses, and so it can exacerbate these symptoms in those individuals. Sleep and circadian disturbances can also lead individuals to being less resilient to stressors, so stressors at work or at home, which in itself could lead to mental health illnesses and - or could exacerbate these illnesses.

This could also lead to the development of other psychological issues, such as PTSD, and may hinder the ability of individuals to respond appropriately to stressful situations. So, for example, in emergency personnel, if they've had a lot of circadian disruption and sleep loss, and they're faced with a very confronting scene, they might not respond to that in the best or the most appropriate way, and this could lead to them developing further mental health issues, or worsening mental health issues later down the track.

Third, and depending on how the individual presents to a health professional, only the mental health illnesses often are treated, and not the sleep disorder or sleep disturbance, and this can be an issue for individuals, because as soon as the sleep disturbance, such as circadian disruption, if their shiftwork returns, the likelihood that the mental illness will return also increases, even if the person is treated, or has been treated, for the mental health illness.

Over the last few years, there's also evidence stating - saying that sleep disturbances are a risk factor for suicidal ideation, suicide attempts, and suicide itself. Suicide events are most likely to occur between the hours of midnight and 6 am, suggesting that wakefulness may directly contribute to some of the trigger factors. This particular link is currently being explored in Australia from the National Coronial data registry to confirm this in the Australian population, and what other factors may underpin it.

So just to kind of summarise, my general suggestions are that, as Dorothy would have mentioned, the Sleep Health Foundation will be putting forward more specific recommendations on the report, and how to recognise sleep health and the associated risk factors for the development of mental health illnesses. We also would suggest to incorporate sleep health into workers' compensation workplace safety tools, and workplace education, particularly for those individuals such as shiftworkers or emergency personnel people who work 24-hours, or around a 24-hour schedule.

It's also suggested that we look at screening for sleep disorders, and the treatment of sleep disorders, and not just the treatment of mental health illnesses, and then some public awareness around sleep health and its relationship with mental health illnesses, such as education promotion may be beneficial, and then education to GPs around sleep health and sleep disorders and how these lead to mental health disorders, and education about circadian disruption. For

example, shiftwork can lead to the development of mental health illnesses.

And then education for psychologists and psychology services around sleep health, and particularly resources on Cognitive Behavioural Therapy for Insomnia, which is shown to be more effective, particularly long-term, than some medications, which I believe Dorothy kind of touched on briefly there. All right. So that's my opening statement. Thank you.

MS ABRAMSON: Thank you very much. For the benefit of the transcript, that was Dr Gemma Paech from the Sleep Health Foundation. I have a couple of questions, and then I'll ask my colleague. We're very interested, as you will have seen, in young people and young people's mental health and early intervention. I am aware that in, at least in my home state in Victoria, that some schools are starting to have adolescents actually start school later, to recognise that their body rhythms are different. So I'm just interested in a practical way about some of those type of recommendations.

PROF BRUCK: I'm happy to answer that question. I believe there's one school in Victoria.

MS ABRAMSON: Templestowe, I think.

PROF BRUCK: Sorry?

MS ABRAMSON: Templestowe, I think. College.

PROF BRUCK: Okay, all right. Well, then there's another one. There's one in Mount Macedon as well that does start later, and there's a large body of literature around this that suggests that it's actually very beneficial for adolescents. But it's not without its potential dangers as well, because we know that puberty is associated with later going to bed, later rise in melatonin, and a tendency to want to stay up later and not get sleepy so easily.

And so we know that over two-thirds of young people regularly get only about - get less sleep than what they actually need on the school nights. Now, if you have a later starting time, in theory, that means they can sleep in a little bit. They're more in sync with their body clock, and then, you know, they just - everything works much better and they don't have that sleep deprivation. But we really need to have proper studies to - you know, field studies to know that this is the case, that they're not just even more advancing their circadian rhythm, that they're not all going to bed even, you know, two hours later than they normally would.

So, I think my short answer is yes, it sounds like a very good idea. It needs to be trialled. It needs targeted research to find out. I just know anecdotally from my own son's high school, what they did was the postpubescent children actually had to go to school an hour earlier for classroom reasons, and that just seemed to be crazy.

MS ABRAMSON: Thank you. The second question I wanted to ask is about GPs, and certainly in the context of our report, we've had some conversations about GP training, and it's like teaching. There's a huge number of things that have to be taught in the formal sense, but what would you be proposing with GPs?

PROF BRUCK: Do you want me to answer that, Gemma?

DR PAECH: It's up to you. I can add a little (indistinct) here. I think GPs, you know, traditionally they haven't received a lot of education around sleep and sleep health. I know in our area in - around Newcastle, a lot of GPs aren't very familiar with sleep disorders, and a lot of the times, whether because it's pressure from patients, or just because they don't have a lot of time, quite often if people present with a sleep disorder, they'll prescribe a sleeping medication, whether or not that's a sleeping tablet or something like melatonin, and they don't always try and investigate the underlying reasons as to why an individual might be presenting with sleep disturbances.

And so, education around how they can look for different reasons, or the causes underlying the sleep disturbance, I think, is really important, and then education around how they treat those patients, whether it be referral onto a sleep clinic, or referral onto a psychologist service, depending on – depending on what the patient is presenting with. I think a lot of GPs are very keen to learn this, whether or not they have the time and the resources is a different matter. I don't know if you want to add anything extra, Dot.

PROF BRUCK: Yes, I wouldn't mind just saying about sleep apnoea. We know that a conservative estimate is that 9 per cent of the population – 9 per cent of the adult population, may have sleep apnoea that needs treatment. Now, we can't have, and we don't want, the sleep community – the sleep specialist community doesn't want to be treating all those people. These are often fairly routine assessments, and then routine treatment, but the GPs need to be trained, so they can identify when sleep apnoea may be an issue, and what to do about it, and how to interpret the results that come back from a sleep test.

And the Australasian Sleep Association, our sister organisation, has been very clear in saying we don't want all the sleep specialists to be dealing with this vast number of people with basic, uncomplicated sleep apnoea. And so, the GPs need to be trained so that they can deal with those sort of things. And from a mental health point of view, it's absolutely critical, because the links between untreated sleep apnoea and depression are just extremely tight.

MS ABRAMSON: Thank you. Harvey?

PROF WHITEFORD: Thank you. So, staying with the GP for a minute, when the GP assesses a person, they may have both mental health problems and sleep problems, at the same time. And as you said, there's a bidirectional relationship between the two. So, in that situation, it may be hard to know which comes first, and is there any research you can let us know about, or advise about how they tackle that? Is it a case that you just go hard at both, or is there a way of trying to discern a causal relationship between the two?

PROF BRUCK: I think, if I can answer that, Gemma, I think that the key thing is that the causal relationship is not actually that important. We know that poor sleep is often a marker of mental health, and what proceeds one versus the other is not actually the significant thing in treating them. The significant thing is to recognise the primacy of sleep health, poor sleep, in exacerbating the symptoms and keeping them going, and the need to make treatment of the sleep problems complimentary with treatment of the mental health problems. And if you're just trying to treat depression in isolation from the sleep problems that are presenting, then

you're not going to have nearly as a successful treatment outcome, short-, medium- and long-term, but particular medium- and long-term, if you don't treat the sleep issues as well.

So, we're calling for that gap to be narrowed, so for psychologists to have much more training in CBT-I. The APS, who I think are presenting after me, they have an online program for CBT for insomnia, and they have their members doing that. But that, the whole thing, needs to be rolled out much bigger across Australia, and one of the things that the Australasian Sleep Association and us have been arguing is that CBT-I doesn't have to be only the purview of psychologists; that there are numerous examples around the world, especially in the UK, where practice nurses have been trained in how to administer, and how to, you know, deal with CBT-I, and that's been very successful.

It's a bit like sleep apnoea. The issue is so prevalent that you can't just rely on psychologists to do it. That you need it to be in the whole Stepped Care Model. And psychologists have a really important role, especially when the mental health issues have primacy as well. But it can go broader than that, and must go broader than that.

PROF WHITEFORD: Thank you.

MS ABRAMSON: Just one further question: so you put a very strong emphasis on educating – education. What do you think the barriers are for that actually happening? Because I think you've also mentioned in a recommendation that the government should be doing more in that space?

PROF BRUCK: Well, the Bedtime Reading report from the government inquiry recommended a national awareness, and we're adding behaviour change campaign.

MS ABRAMSON: Yes.

PROF BRUCK: Look, I think it's just not in there. We've had two reports recently, this draft mental health report, and the preventative health draft report, and neither of them mention sleep health.

MS ABRAMSON: This is why we have draft reports and have hearings.

PROF BRUCK: Yes, this is why I'm here. It's because diet and exercise have been pushed really – a lot, for the healthy lifestyle, but we argue that it's actually three pillars and sleep has to be the third one. And the reason why education – sleep is not there in the education, if we're talking about early intervention, is because it's not in the public consciousness, either. You think healthy, you think food, exercise – they don't think sleep, and so all of those, you know, people doing health education in schools need to have that education in sleep as well, so it's a whole lifting up of the awareness across the community so that it's ubiquitous.

PROF WHITEFORD: (Indistinct).

DR PAECH: I just want to add on to that point, if I can. Part of the terms around education, particular public awareness, is also some misinformation that gets put out there. You do have a lot of people that will report themselves to be sleep experts, but don't have any official

training, and I think the support from governments to recognise official bodies, like the Sleep Health Foundation, and the Australia Sleep Association as kind of the gold-standard for providing that education, as opposed to a lot of other individuals who might just read a text book and decide that they want to do that.

The other thing with training some individuals like GPs and whatnot is time and costs associated with it. A lot of them don't have the time, and a lot of them don't have the resources to access that training education.

PROF BRUCK: Could I just add to that; a lot of people think that helping sleep is about sleep hygiene, which is a word I don't like at all. But you know, sleep hygiene is a series of tips, you know, about caffeine and routine and thing like that, and it's one very, very tiny part of cognitive behaviour for insomnia. So I think part of it has been this misinformation that if you have a page of tips you'll be right, and that's far from the truth.

MS ABRAMSON: Thank you.

PROF WHITEFORD: Sorry, one more question. So we've heard a lot about the ability to put CBT online, and either clinician moderated, or clinician not-moderated for common anxiety, depressive disorders, and a lot of research has been done to the effectiveness of this, as I'm sure you're aware. My question is whether CBT-I has been moved into an online CBT framework or not, and if it has, can you let us know where, and too, if it hasn't, would it be adaptable to that method of spreading it's coverage across the population?

PROF BRUCK: Do you want to answer that Emma, or should I?

DR PAECH: That's fine, I think you've got this one, Dot.

PROF BRUCK: Okay. Yes, CBT-I has been made online. There are a couple of programs that have been evidence-based, showing evidence-based utility. And I think the general feeling is that if it has the practitioner model in there as well, so that it's a therapist supported, the problem is that CBT-I for insomnia online is very sleep focused, as you can understand. And when we get mental health, mental illness, into the picture, it becomes much more complicated, and I think it's – you know, as a sleep psychologist myself, I think it's actually really good to have that face to face.

But I think that through telehealth, there's a lot that can be done. So, a combination of telehealth, online materials and trained psychologists, trained practitioners who know about CBT-I, I think is actually the way to go. I think, if we just expect people with complicated mental health issues, or acute – severe mental health issues to just do an online package, I think we're not going to get very far. Because the evidence suggest that they don't sustain it, unless there's that face to face interaction, and that concentration on their own particular manifestations of how their mental illness is affecting their sleep.

PROF WHITEFORD: So, can I just follow up on that. So, nevertheless, would it be important that in the various modules that we do see for the various targets that CBT online, I guess, comprise to provide some input, that even having CBT-I there, as an option, would raise awareness of the issues that you're pointing us to, and perhaps be a pathway to engaging in that

once you've become aware that it is perhaps a more significant component of what's going on or even maybe in the causal chain than would otherwise be the case.

DR PAECH: I would agree with that, yes, definitely. I think it's definitely got a place and the work that they've done in the UK shows that.

PROF WHITEFORD: Yes, so I wasn't suggesting that that is the answer to our problem but I'm thinking of trying to, I guess, create the awareness that you're suggesting is absolutely necessary in the area of sleep health.

DR PAECH: Yes, yes.

MS ABRAMSON: Thank you very much.

DR PAECH: Thank you.

MS ABRAMSON: And I think now we're going to dial in other people, is that right, Lisa?

PROF WHITEFORD: Thank you very much, Gemma.

MS ABRAMSON: Thank you.

DR PAECH: Yes, thank you.

MS ABRAMSON: Could I please invite Ms Knight from the Australian Psychological Society to speak and if you'd be kind enough to say who you are and where you're from and I'm sure you have an opening statement.

MS KNIGHT: Indeed I do, thank you.

MS ABRAMSON: And if your colleague would also be kind enough to announce her appearance for the transcript, thank you, and where you're from.

MS KNIGHT: I'm Ros Knight. I'm the president of the Australian Psychological Society currently. I'm also involved in training the workforce so I work at Macquarie University running training clinics for lots of psychs and I'm a practising clinical psychologist all of which inform my answers. So firstly let me thank you for the opportunity to present. I know you've got a very busy schedule so we're very grateful for this opportunity. We will be putting in a very comprehensive response to your questions in the draft report as befits a very broad discipline we thought we can speak to a lot of it so all I'm going to talk to today is just a couple of points where we think maybe there's some misunderstandings and a couple of gaps and the rest will be in our response and equally any questions you ask me I can't answer on the spot will make its way into the response.

So our overriding concerns when we look at the document around safety and quality of what's being delivered for consumers, the workforce capacity to deliver that for consumers and the sustainability, of course, of the budget and everything else that goes into making this roll out happen. We are yet to decide about whether we think option one or two are better options

because as befits most of what I'm about the say the devil, I think, is in the detail around - - -

PROF WHITEFORD: Options one or two?

MS KNIGHT: In terms of the RCA or the PHN modified model.

MS ABRAMSON: Yes, so rebuild or the renovate.

MS KNIGHT: Renovate, yes. So the detail I think is where we're sort of hesitating. So to talk through the main points for today I think it's really important that we communicate clearly that the psychology profession is very much in favour of outcome measures for the MBS process. In fact we actually think that there's a suite of measures that are pretty much good to go that have been trialled within the public sector and could be rolled out not just for MBS but also for PHN, headspace, private sector, and I think our main point would be to say while we're concerned as well that the MBS hasn't been appropriately evaluated we are concerned that probably no agency really appropriately evaluates outcomes that well for psychological services so we would be keen to engage in that but would like to see that rolled out across the board.

Now, clearly they have got to be appropriate measures. We can't have measures that are on the extremes so suicide rates per se is not a great measures of therapeutic outcome but neither is complete recovery sometimes so we just have to think about how we best measure, and particularly in different steps, what the outcomes should in fact look like.

Stepped care: again we strongly support the Commission's focus on trying to improve stepped care so again what we are more concerned about how we manage the steps between, without turning it into silos again because that's not helpful, but making sure that the people involved are actually able to produce what you need them to produce in terms of client care. So our sense would be that there's a lot of people who would like to be in this space and we would be - and think it's great, I want to say that upfront, peer workers engaging teachers to do more, nurses, GPs, all of that is all good. Our observation would be we don't want them to experience burnout and concerns because they start to overreach so making sure there's appropriate education and training around what they can do and when they need to pass that on is pretty important.

In terms of psychological interventions per se we clearly see that there's a role for psychology in lots of different ways from assisting say the peer workforce with supervision or the online programs again with sort of supervision and oversight all the way through to assists psychiatry who of course have significant numbers problems up towards the pointy end with particular areas of practice, psychologists, so, yes, overall again just saying we support the stepped care model and what you're trying to do but I think it's just got to be managed well so that we don't end up either in silos or are conglomerate of everyone who thinks they can do everything.

One of the areas in the draft document that caused us a little bit of pause was the assertion that we didn't need any more psychologists within Australia. We have had a look at the statistics and actually think we're actually relative to western Europe, we're actually underrepresented within the workforce so we actually think that may be a misstatement perhaps due to data that

was given to you but equally there's an assumption when we look at 35,000 psychologists that all of them are working in mental health or all of them are actually involved in therapy at some level and that's not true. We estimate from AHPRA's data, so this is available to the Commission as well, that probably around 50 per cent of the psychology workforce work in counselling or that sort of therapeutic intervention and the rest are working elsewhere.

Now, some of that is still stuff that would be relevant to the Commission and to mental health but a lot of it is not. For example, psychology management, consulting, research, organisation practices, those sort of things so over and above we're slightly concerned I suppose at the suggestion that we won't need more, we actually think we probably do and in particular you mention public system that everyone's leaving. Again, we would challenge the view that we're leaving because it's better placed work privately in terms of the finances. It's actually as much because the public system is very difficult to work within these days for psychologists.

Activity-based funding really needs a solid thinking about what that really means. A lot of psychological services aren't as simple as just sitting in front of a client and billing, that, you know, case work report writing that's comprehensive, all that takes time and if that's - and supervision - if that's not included in activity-based model then it's very hard to do your job. I also know that there are quite a few psychologists who struggle in private practice, most of us are part time in fact so the funding argument really doesn't carry a lot of weight.

There's also issues of course you've noted about getting out into rural communities and we should just encourage the Commission to think about ways to incentivise people to move out but also acknowledge the role of online and telehealth as being a fantastic option there. Probably the only other gap I would point out is that at the beginning of your draft you mention that this is not to do with neurodiversity sort of issues - - -

PROF WHITEFORD: Not to do with, sorry?

MS KNIGHT: Sorry, my mind's just gone blank. But not to do with dementia and other cognitive - - -

MS ABRAMSON: And cognitive issues, yes.

PROF WHITEFORD: Yes.

MS KNIGHT: We would argue that cognitive assessment however should be included. You know, we've said that in our submission to you and also into the MBS submission that it's really an artificial distinction to say that cognitive assessment doesn't inform how mental health practice works. It's been used even at psychosis levels but equally if we're talking about early intervention in schools, things like ADHD - you know, a decent assessment around all of that will help direct early intervention into kids but equally up the other end of the spectrum, you know, do we know if it's dementia or do we know if it's depression? So I think having sort of gone, 'Yep, we're not talking about that sort of thing upfront' I'm just enquiring whether that can be reconsidered. And that's it.

MS ABRAMSON: Thank you very much. I should apologise. We're having trouble with our Bluejeans so the phone in front of you is for the purposes of some of our staff and hopefully

Commissioner King who wasn't able to come today. Harvey.

PROF WHITEFORD: So just starting with the last question, the issue about - I think the trying to limit the scope to what we thought was manageable, I'm not sure we managed to do that but it wasn't to say that neurocognitive issues through the lifespan weren't relevant, it was more to say perhaps aged care, which was being dealt with by our Royal Commission et cetera, would be an area where we might put less focus on given the other areas we had to cover but certainly trying to understand the contribution that impaired cognitive functioning is making to individuals who may have psychological systems et cetera would certainly be within the scope and I agree that the availability of neuropsychological assessment hasn't been something which has been perhaps focused on historically or even maybe in our report as we could so we'd be interested in ways in which that could be supported. For example, there have been suggestions should the MBS be modified so that neuropsychological assessment can be done and reimbursed through that mechanism. If the Society has any comments about how we could remunerate that we'd be interested to hear it.

MS KNIGHT: Yes. I think because it can be a discrete item, it fits well within MBS but equally if it moved towards a more team-based approach of course it would fit within that model of package I suppose but at the moment under current funding options it would fit.

PROF WHITEFORD: It would fit, yes, and I think there was a difference between, you know, psychological evaluation and then the treatment or interventions that follow that which is a different question really as well but both important at this stage.

MS KNIGHT: Yes.

PROF WHITEFORD: So then coming back to the supply issue. Have you got data from Europe or the UK or where the ratio of psychiatrists whose population - - -

MS KNIGHT: Yes, 100-150.

PROF WHITEFORD: Right. I'm sure we've got that but I'd like to make sure we have got it. So that would be in your submission that's going in in January?

MS KNIGHT: Yes, it will be. We'll flesh that out in more detail definitely.

PROF WHITEFORD: Yes. And especially I guess the other issue when we're talking about workforce it's across the lifespan is also valuable for us. As you know we have done some work with the National Service Planning Framework (indistinct words) looking at workforce for child and adolescent versus adults versus older ages et cetera so we've found when doing that there tends to be an undersupply of mental health professionals circumscribed by age as well so again if there was any of that sort of information from other countries which have looked at this we would be grateful to receive that.

MS KNIGHT: Yes. I believe our written submission will have quite a lot on the child and family area actually but I've decided not to raise that today because that will just be answering your questions.

PROF WHITEFORD: Yes, sure. Do you have a question?

MS ABRAMSON: Yes, I wanted to ask you about private health insurance and you will have seen that there was a recommendation from us that we would actually like more to be able to be done in the community and I understand that of course that you're very supportive of doing that but I'd like to know what would that kind of look like, what type of services would you be thinking of?

MS KNIGHT: So if they were able to work in the community they could in the first instance act as a better add-on to the MBS so I know you've proposed up to 20 sessions which would be fabulous but at the moment of course the rebate from private health is very, very small and fairly tokenistic, if I may use that phrase, so I think it would have to be a more comprehensive package around that so that would be an obvious backup to the sort of clients that go into private hospitals, when they're discharged being able to provide some additional funding around services outside would be really good.

At the moment also as you know they have to participate in group to get services within the private system after they've been discharged and that's not always a great way to do therapy either, prescribing a particular type of therapy so - and in a sense is costing when it doesn't need to.

MS ABRAMSON: Just on that point because we've been talking about in community, as you know we're very concerned about regional services so I'm just wondering what sort of proposals you might have from your organisation that would support psychologists in the regions?

MS KNIGHT: So let me just say I really liked your PHN suggestion. I thought them topping up funding and providing some incentives was an awesome idea and definitely think the telehealth thing is also an awesome idea. To kill, we'll call it multiple birds of stones we did wonder about that ability to somehow if not start courses in regional and remote areas at least provide placements and internships out there. The psychology workforce struggles with appropriate placements and internships as it is within the system and I won't bore you with all of those details today but clearly if people have gone to a rural and remote area to do a placement or to do an internship they're more likely to stay if they can get work out there, if they've enjoyed it.

So we do think that model of trying to at least get some basic training - you know, medicos have to do a rural and remote placement as part of their thing so the difficulty there is appropriate supervision and things like that so that would be our main suggestion I think over on top of what you've already suggested and I'll just - yes, so the rural incentives like you say through PHN was probably not a bad way to do it.

MS ABRAMSON: Thank you. The other question too is you mentioned before about the payment from private health insurers being quite minimal. What sort of - do you have any data evidence about consumer willingness to pay and take up of services?

MS KNIGHT: We can come back to you with that. Through the private system do you mean?

MS ABRAMSON: Well, generally it would be very useful for us but the private system in

particular.

MS KNIGHT: Okay.

MS ABRAMSON: That would be very helpful.

PROF WHITEFORD: Sorry, that's the rebate for face to face psychological treatment, the higher private health insurance coverage packages that you were referring to.

MS KNIGHT: Yes.

PROF WHITEFORD: Yes. Compared to the MBS rebate it's much, much lower.

MS KNIGHT: Very.

PROF WHITEFORD: Yes.

MS KNIGHT: And I think prohibitive even for those who are paying quite a lot of money for private health insurance can't afford to pay that much over and above - - -

PROF WHITEFORD: Just on that though, we have heard that a number of the private health funds, you might have seen some of the media coverage on this, are very keen to offer community-based treatment for people who have been in hospital.

MS KNIGHT: Yes.

PROF WHITEFORD: Do you have any word on whether that would include psychology as well or you're not - you maybe haven't got that covered?

MS KNIGHT: We haven't had - - -

PROF WHITEFORD: No, so Medibank Private and BUPA and some of them are looking at persuading the government to allow coverage of non-inpatient and non-day patient treatment.

MS KNIGHT: Awesome.

PROF WHITEFORD: And we think that's a positive thing.

MS KNIGHT: Yes, yes.

PROF WHITEFORD: And I guess it would be useful to help understand for mental health patients what that means in the community given that some medical and psychological services are covered to some extent by the MBS what else would the private health funds cover and if they are going to cover that it would be at a level which would ensure that patients/clients could access.

MS KNIGHT: I think my comment there would be to say that depends on how much change happens to the MBS in the next little while so if we do extra sessions and it covers a broader

range of problems et cetera then whether they would just add-on, top up or whether there'd be particular things that they would be better focused on our hope is the MBS starts to actually address all the mental health needs of the community rather than a very narrow range of topics.

PROF WHITEFORD: Yes, so I think focusing, without wanting to pre-empt private health, would be interested in I would suggest that they're going to be interested in people who have been in hospital and are more likely to be readmitted to hospital. The MBS perhaps tends to focus on most of its activity on patients who (indistinct words) hospital and don't need to go to hospital so it could be complimentary if it's designed the right way and I guess we would be hopeful that in designing that the differences in those patients or population cohorts would be considered.

MS KNIGHT: Yes, yes. To me they're obviously different to the cohort that have been in public hospital with mental health issues, they're not as severe but still that same revolving door phenomena trying to put in place programs that will stop that from continuing, absolutely.

PROF WHITEFORD: That's certainly the intention, yes.

MS KNIGHT: Yes.

MS ABRAMSON: I just have one final question, I wanted to ask about school-based psychologists because I understand that you have an interest in supporting national standards et cetera, where we've gone in our review, as I'm sure you've seen, is for the wellbeing teacher in the school and a referral out to services and we're aware that I think both New South Wales and Victoria do have programs for psychologists but they're quite small in number I think given the cohort that they're to cover so I'm just interested in fleshing out a bit of more what you think in terms of psychologists in schools, what you'd like to see.

MS KNIGHT: So we agree that New South Wales and Victoria, it's fabulous what they're doing, that they're trying to make that presence felt and New South Wales has got social workers in it as well so it's trying to actually get a whole lot of stuff covered. We agree though that probably one in 500 - sorry, one psychologist to 500 is probably what we're looking at so for some big public schools one is going to really struggle to do that and probably the other thing I would add is it's - again, really like the wellbeing teacher concept. I think that's a fabulous idea. They would need to have a good sense of when they refer on who would they consult to work out what to do with that and trying to work out a more streamlined process to refer out because I know they often then get stuck going, you know, where do I send them? Do I just phone down the list of 20 or whatever, so I think there's a process there that - - -

MS ABRAMSON: I think in our model we envisaged - because we had a view that we would work to improve the support that's available in the community, which is why we were not focused on actual services being delivered within schools, but also in our model with the RCA we were also envisaging a close relationship with the local school community to deal with exactly what you've been talking about.

MS KNIGHT: Yes, and we're aware that in Tasmania there's been an effort to roll out a better program through (indistinct) psychs down here. So I think Tasmania has probably got a good example of something that is working a little bit better.

MS ABRAMSON: Could I also ask what role - we've had a lot of representations from counsellors.

MS KNIGHT: Yes.

MS ABRAMSON: And so I'm interested in your organisation's view of the type of roles that counsellors could fill.

MS KNIGHT: Sorry, counsellors as in?

MS ABRAMSON: As in general counsellors.

MS KNIGHT: At schools do you mean or - school counsellors?

MS ABRAMSON: No, no, as in - what's the best - - -

PROF WHITEFORD: So I think the issue is the difference in what counsellors - that's members of the Australian Counselling Association or PACFA can do versus members of the APS.

MS KNIGHT: Yes.

PROF WHITEFORD: And then clinical psychologists as you know versus - - -

MS KNIGHT: Registered.

PROF WHITEFORD: Yes.

MS KNIGHT: Yes.

PROF WHITEFORD: So that whole continuum of counselling or psychological care, treatment, whatever has been a real focus for the feedback we've received. A lot of it has been around where MBS rebates should go. But even leaving that aside, I think we want to understand - we'd like to understand in the Commission is where that workforce could be best deployed and urban versus rural or types of care. So where in your view does psychology fit into that versus counsellors who aren't - don't have psychology qualifications.

MS KNIGHT: Sure. Happy to attempt to answer that. I do actually work with counsellors so I have some experience of this nexus. Counsellors fill a great role in terms of - if I may answer it very detailed, in terms of helping people to work through their issues and come up with their own solutions to enable them to be heard, and then to come up with a solution. So the training therefore is much shorter. It's not about trying to work out diagnosis and implementing full treatment programs at that level but - and that's not to say they don't have treatment training, but it's definitely designed for - call it an early intervention sort of piece and that sort of basic level, which at some point needs to then be passed on if it turns out the person has more significant mental illness issues.

So that would be that bottom piece. My hunch - I'll speak a hunch, is just that for those who don't want to do online, who need the person to talk to in the first instance to help them work out what they're doing, that that's actually not a bad way for counsellors to be involved. That there is still a huge market for people who want to sit with somebody to work through their issues. So there's that. Working to the top of performance, all psychologists can diagnose and treat at least at a basic level for mental health. That's part of the basic training. So all psychologists fit in that middle ground of somebody who's now been diagnosed as - well, like I say it would be nice to be beyond depression and anxiety to a range of issues.

And working at the top of that level would be expected to do up to 20 sessions on a range of disorders, I suppose. And then moving more up to the pointy end as befits the PsyBA requirements, and we believe there's a range of expert psychologists who have skills in different areas. So if I use educational and developmental psychs are experts in the school domains and child development areas, as well as obviously clinical has got a name for itself in terms of severe mental illness. So it sort of moving up in that sort of area, was where - would be where we would see that shift over time.

MS ABRAMSON: I have just one final question which will show my ignorance, so please bear with me. Is it only registered psychologists who diagnose or is it clinical psychologists, and if so what's the difference?

MS KNIGHT: Like I say a basic diagnosis now under the training standards should come from any psychologist. The difference would be the degree of differentiation once it becomes more complex and comorbid that separates out the more AoPE type. I think that's the best way to put because it's not even severity, you know, somebody who's flagrantly psychotic, most people can have a pretty good stab at diagnosing that, but when it's complicated by a range of issues that's when it takes further assessment and intervention.

MS ABRAMSON: Thank you.

PROF WHITEFORD: I've got one last question also.

MS KNIGHT: Please.

PROF WHITEFORD: On the stepped care model we talked about - going back to the issue of counsellors for a minute, from you've said, counsellors could be deployed down the low intensity end of that continuum for people who have risk or who have symptoms that don't yet reach the threshold for a diagnosis et cetera, trying to I guess increase that early intervention component at the low intensity end. Yes.

MS KNIGHT: Yes.

PROF WHITEFORD: Thank you.

MS ABRAMSON: Thank you very much, and thank you also for your continuing work with the Commission, it's much appreciated. Thank you.

MS KNIGHT: Thank you.

MS ABRAMSON: Could I please ask our next participant, Ms Martin-Cole. If you'd like to take the - I was going to say the stand because I'm a lawyer by training but it's not the stand, it's just the seat, announce your name and where you're from and I'd also invite you to make an opening statement should you wish to do so.

MS MARTIN-COLE: Yes, I'm Tracey Martin-Cole from Psychology CAFFE, which is in the north-west of Tasmania, and I had quite a bit I wanted to cover, so I have actually documented it. So if I could talk to that. We've been in the community for the past eight, nearly nine years and we were established in response to a community need in a rural regional area for child and adolescent services particularly. So I am a psychologist by training. Also a play therapist, and I'm a Board approved supervisor for psychology and also for play therapy. So Psychology CAFFE is a multidisciplinary group private practice. We started with just one building with six consult rooms and offering individual, family and couple sessions under MBS and private health, and helping children with autism and other funding streams and also full fee.

We now are expanded and servicing the remote and rural area of around 15,000 square kilometres across nine locations in the north-west. So we're actually rural, remote and regional. We're registered with the NDIS. We have several PHN contracts and we provide third party MBS and insurance consultations. Eleven per cent of our clients accessing our funding are identifying as Aboriginal, but yet only represent 3 per cent of the population in our area. Fifty per cent of our clients are children and 60 per cent of our referred clients meet the criteria for moderate or severe mental health presentations, including children and young people. So we provide supervision at the practice and training for peer support, officers for Ambulance Tasmania and we do prioritise consultations for first responders and other health professionals.

So we've grown and expanded and in the last financial year delivered 5000 individual sessions and several group programs to parents and children, including onsite and co-delivered in schools with other professionals and in early childhood settings. So we provide education and training for other services. We host workshops and deliver groups in the community for other professionals and organisations, as well as parents and carers. We host university masters students on rural placements in psychology, social work and medicine through UTAS, and we're also an organisational member of the Mental Health Council of Tasmania.

So it's a quite a large practice and we now actually are co-located in six locations, which is in medical practices and rural health centres in Deloraine, Sheffield, Devonport, Smithton, West Coast and Burnie. We - - -

PROF WHITEFORD: Sorry, run through those again.

MS MARTIN-COLE: Deloraine - - -

PROF WHITEFORD: Yes.

MS MARTIN-COLE: - - - Sheffield, Devonport, Smithton, West Coast of Tasmania, and Burnie.

PROF WHITEFORD: Right. Thank you.

MS MARTIN-COLE: We also have two standalone health centres in Latrobe and Ulverstone in very central locations, and we have a total of 15 mental health clinicians. They all have accredited mental health degrees and additional training and supervision. So they consist of psychologists, mental health social workers, a mental health occupational therapist, a mental health nurse and we're also co-located with a psychiatrist and a speech therapist. So we're quite comprehensive. We have lots of challenges. We have a lot of families with very low socioeconomic status. We have higher rates of mental illness and behavioural and emotional disorders in children, and we have acute suicidality in our community sector, much higher than most of the rest of Australia behind the Northern Territory.

So we have increased demand and severity in our community sector, and we've had a wait list for eight years. We've reduced it down to two weeks at times, but generally, it's up to 4 to 6 months for children, regardless of the number of people we can recruit. So, our biggest challenges are efficiencies with funding cycles that tend to be short, and a bit behind, often. So we have challenges with recruitment, with retention – the way we've addressed recruitment is to be a bit creative and persistent with our networking.

We've now, actually, finding it's much easier to recruit, but only because of the work that we've done over the past years, so we've increased our focus on culture within our team, automation of structures in our practice, so we've moved from a very traditional, private practice to quite a comprehensive, multidisciplinary team, and our retention has improved, with a strong focus on prevention of mental health difficulties in our own team, and burnout due to the pressure of the constant high demands, severity and complexity.

So we provide: weekly group and individual clinical supervision; regular training; whole team planning; and CPD days. We have static diaries – dynamic for clients, but static for us, so we close the practice, and we have an hour's lunch and those sorts of things. So, for us, our challenge has been, you know, addressed fairly creatively. The other issue for us is poor integration of the state and federal mental health funded systems. So, that's been promising for us to read that that's been looked at.

We're attending forums and community events as much as possible to advocate for rural/regional areas, and particularly for improving pathways between state and federal. Because we're in the community, and the commissioning's only really been in the last three years, what we've found is that the pathways aren't there, and so the documentation's about four years behind in terms of connecting up those two, you know, community and mental health services. So, for most of us, we've worked in mental health service settings, in the past, and we've moved into private practice so that we can actually be with our colleagues, and feel more supported and engaged with our community.

So now we're facing challenges of accessing psychiatry in particular, and that's across the board. Telehealth isn't very helpful for us, because you go to Strahan, and actually, if it rains, you don't have internet, so we have to drive there for two and a half hours to do face to face consultation. The patients/clients are often quite happy to see us, by phone, even, which fortunately the PHN has made possible. So, we're actually able now to deliver services that we couldn't before.

My biggest – my thought is that the biggest gap is actually for children five to 12 years, and families that have children in that age range. Our GPs, our referrers, our schools, the staff, are all quite distressed, and actually, you know, are finding that they're – the despair is quite high, because most of their work is now actually managing those families and children. Paediatricians saying to us, you know, 'I didn't get into this to help children with behavioural problems, I was here to look at medical issues,' and more and more it's becoming much more complicated than that. So, most of our referred children are actually in that age range. A lot of services for 12 to 18 in the community - - -

MS ABRAMSON: Is that the headspace services?

MS MARTIN-COLE: headspace, Cornerstone, our PHN is invested in that. There's the youth engagement team, which is for severe mental health in the community; recruitment's a challenge for them, training's a challenge for them. So we're often asked to provide that.

PROF WHITEFORD: Have you worked with that headspace team?

MS MARTIN-COLE: Again, it comes back to local relationships, unfortunately, and so building that with management, in a rural context, and the same with the CAMHS team, to be able to - - -

PROF WHITEFORD: Cam team?

MS MARTIN-COLE: Sorry, Child/Adolescent Mental Health in the State.

PROF WHITEFORD: State government, yes.

MS MARTIN-COLE: Yes, yes. So, the acute service. So we actually are still relying on relationships without our local area to facilitate those connections where there's cross-over, particularly in stepped care, obviously. Some of those youth are going there for one or two sessions, and then coming to us, but our funding doesn't support that. So then, the biggest challenge is accessing services, and being able to pay.

PROF WHITEFORD: Could you just run through here your funding does come from, overall?

MS MARTIN-COLE: Well, because we're a private practice, we actually have funding from every direction. We have clinicians that work, fully privately, so they will actually see children full-fee. Some of those families can access NDIS funding, particularly where there's co-morbid presentations. But other families access a Medicare rebate, but they still have to pay full-fee, because in a rural area – we've actually had some benchmarking done to be sure that we're cost effective, and then looking at, you know, our ratios, to admin to clinical for a GP to work in a rural practice, they can support a receptionist or a nurse, just with one practitioner. But in psychology, you can't do that, and certainly the rebates are – have been frozen, for, you know, the last nine years.

PROF WHITEFORD: You're talking about the MBS rebates.

MS MARTIN-COLE: Yes, MBS rebates.

PROF WHITEFORD: So, full-fee – when you say full-fee, you mean the schedule fee?

MS MARTIN-COLE: No.

PROF WHITEFORD: Or the APS fee?

MS MARTIN-COLE: No. Well, some of them are APS, because we actually have multiple third party payers, but our standard consult fee is \$180, or 120, depending on whether it's our principal or our senior clinicians, so the rebates vary anywhere from 50 to – well, 50 up to 120 for an endorsed psychologist, but we don't have any of those in that team of 15. We have several working towards that, that are registrars, but the majority are generally registered. Sixty per cent of our clients that are referred are actually severe and complex, so like I said, I have some concerns about workforce development, particularly with the MBS review, and the paper put out by the APS referring to the workforce, you know, and to what they call 'advanced practice'.

Because we're already doing that, but because we're in a rural/remote area, there's no recognition of prior learning accounting for since 2010. So, you know, for many psychologists and other professionals in mental health, because we are actually committed to working in a rural/regional area, we don't have access to those degrees that are APAC accredited, which are quite limited.

PROF WHITEFORD: 'APAC' meaning?

MS MARTIN-COLE: The body that accredits the degrees, towards endorsement.

PROF WHITEFORD: 'Endorsement' meaning? Sorry about this.

MS MARTIN-COLE: Area of practice endorsements, sorry, AoPE, which is addressed quite substantially in the APS paper, and is part of the reason that there are such a large number of submissions, I believe, to yours, and also the MBS review, in terms of the restriction of the practice that that represents, and the restriction of access. So, the argument is, given that we're not restricting your practice, people can come and see you, but the reality is that in rural and remote practice, they can't afford to do that. You know, the challenge as to distance and access and finance, because you've got much higher rates of unemployment, and much lower rates of education, and therefore, you know, much less capacity to pay.

So we have substantial PHN funding, as a result. We actually approached them a number of years ago now, and we've been delivering – so, this is since 2013, through the local PHN for Child and Adolescent Practice.

MS ABRAMSON: How does that work? Have they commissioned you to provide the services?

MS MARTIN-COLE: Yes, they have. Yes. Originally, just for children, and then we added parents, because we found that once you're in the community, particularly a rural community, it's very much word of mouth and reputation, and they don't – you know, they want to know what they're traveling or, what they're accessing is going to be of use to them. So, the primary mental health care minimum data set, which is a new version since 2016, has all of the data in there. So we would love – this year's the first year we've actually had really good feedback from them, in regards to the outcome that they're tracking in that portal. So, the evidence is there to show that what we're doing is working, but it's not really – it's a bit behind in terms of feeding that back. I'm not - - -

MS ABRAMSON: Can I strongly encourage you to put a submission in? Because, what you're talking about with the model, how you're doing commissioning and the rural and regional is really interesting, so I really encourage you.

MS MARTIN-COLE: It's a very – it's quite unique. We thought that – and it really has grown from the ground, in a very organic way, and we've had to upskill in the way that we deliver the service, and obviously implement policies, procedures and, you know, processes that a normal private practice wouldn't have, and then after that we've also had to look at the way that we recruit, and the way that we retain and train clinicians in our area, otherwise we wouldn't have enough. We don't have enough, and that is – I was pleased to hear Ros Knight say that, because, you know, the capacity, it's a challenge across rural and remote, of course, but also urban practices that I've spoken with, and I think that's a result of reduced stigma, increased awareness of the challenges, but I think that there are a lot of challenges for our children and adolescents that aren't actually, you know – we're not really aware of them adequately, I don't think.

So, to have hubs in schools, I think, is – or, in communities that are very closely connected to schools is really important, so I would love to put in a submission, and I plan to do that. It's just the time, because we're so busy delivering the services I think psychologists have a responsibility, if you like, to actually start to educate our communities about what we do and what we can offer and I'm finding that we're getting a lot of excellent feedback actually from staff.

Last week we delivered training to the kindergarten and early childhood staff at our local primary school around attachment and brain-based parenting, how that looks in the classroom, how that - you know, how to check how a child's tracking when they come into the classroom and what to do about that and where to send them if they think it's appropriate, that sort of thing. So, you know, at our recent youth mental health forum in Hobart there were a very - I was very impressed actually, there were a lot of paediatricians and GPs who had taken time out of their clinics to actually talk about it and that was one of the biggest outcomes was that we really need that in schools for 5-12 year olds, there's a massive gap. And also peer workers in schools, in senior schools in particular - - -

MS ABRAMSON: What does a peer worker look like to you because we've heard different sorts of descriptions?

MS MARTIN-COLE: Yes. So the first responder peer workers that we work with I love working with that cohort of very brave people that actually have stepped up in a volunteer role

to actually be available to their co-workers. From that we've actually had a lot of referrals of first responders for assistance with PTSD and, you know, they've been working in that area for 12-14 years and they've never accessed any assistance. Often sleep, as we've heard already this morning, is actually one of the first signs - or lack of sleep. And symptom of, you know, things not being quite in balance or correct for them so our focus is to help them look after themselves and find ways through that. I think you asked a bit more there than I've - - -

MS ABRAMSON: No, no, that's fine.

MS MARTIN-COLE: That's one version. And a peer worker in our practice, which I would love to have some funding available for that because I'm not sure - you know, obviously it's a private practice so it has to be billable time so I'm not sure how we would remunerate them appropriately but I can definitely see a place for someone to come in that's been - and we have multiple - we had a visit from a health minister, Greg Hunt, and also from Scott Morrison in the past two years and a number of families came in to talk to them about their experiences with mental health challenges, how it's impacted on their work, their capacity to work or engage in education because they're at home caring for children and for adults and for older parents that have mental health issues and health issues combined and they've talked at great length actually about how they would like to give back and help other families so I can see a role for a peer worker would be actually potentially a parent with adequate training and support that would actually be in the practice to help families engages and perhaps visit schools and go to homes when they're a little bit - you know, like, transport's an issue or they're fearful of accessing services, they don't know what that might look that, they can help them get to the practice, understand what that looks like.

I think there's quite a - New Zealand has a model that they're already doing that with young people and the young people; come in and they actually design the practice. One of the reasons we've been so successful is that a number of us have worked in hotel management when we've had other careers and so we've always had the - and I've worked for charity organisations and trauma centres where therapy starts at first contact, therapy starts at the door. You know, when I was working in the CAMHS team we actually had lockable swipe cards and airless - you know, no windows in the rooms, you know.

For a traumatised child to come into one of those rooms was actually traumatic on its own for us, you know, it's about the environment, it's about being engaged in the community so peer workers I think are young people and potentially parents in our case and other adults that could assist them to come and access services. I also think that would take the pressure off the practice team in terms of, you know, for us we used to be able to greet clients at the door, get them a cup of coffee, settle them in, explain the process, but literacy is an issue so filling out a form and then signing a consent form can be challenging. Now my team are so busy, and it's been phone calls and enquiries, that they don't have time to sit down with that person like they used to do so I think a peer worker would be invaluable in that place as well.

MS ABRAMSON: This is a really interesting model. My team are going to have a look at it here, the submissions are 23 January, but what you're saying today is really interesting so please contact us if that timeline's a problem for you.

MS MARTIN-COLE: That's okay, I can do that.

MS ABRAMSON: I wanted to ask you about stigma because clearly people are accessing your services and one of the things we've heard is a challenge in regional and remote is people not wanting to be seen accessing psychological services so you've obviously overcome that.

MS MARTIN-COLE: Yes. For instance, on the west coast of Tasmania you have a 30 minute drive average between Queenstown, Strahan and Rosebery which there are four main - and Zeehan is the other - there are four communities on the west coast. When we started delivering services we realised that, you know, the people that were living in Queenstown wanted to come and see us in Strahan and vice versa for - you know, they have relatives in those towns so that was a reason for them to go on a day off and actually visit but it also meant they were less likely to be seen by Fred up the street who might see them walking in.

We were initially sort of hoping to deliver services alongside the GP clinics, particularly given the remoteness and also the health centre but they were bang smack in the main street and so we actually chose to deliver our services in an office a little bit further away, that also helped. The clinic in Strahan were very supportive of us. We were told by the Tas Health Services, this is again state federal, that we would need to pay \$115 to rent the room to actually see the clients and we had to fill out a 15 page rental agreement to do that whereas, you know, we've just driven - it's a four/five hour trip.

We're only going to be able to fit three or four, you know, at most five clients in in a day so to ask, you know, it was such a hurdle to actually do that so we were fortunate that we had local people in other areas that were willing to allow us to use their space at no charge and that actually - we even deliver to the school because the medical centre one morning was locked up when we got there and we'd driven to another house and there was, you know, a client standing in the rain waiting to see us already so the local communities, you know, engaging with them and the school was wonderful and said, 'Look, you can use our library' which meant that children that were going to probably not access it easily were able to do so. So we've overcome it in quite creative ways at times.

PROF WHITEFORD: Have you found a difference in the GPs in the various areas you have worked in how collaboratively they work with you in your relationship between them; what makes it work and what makes it not work so well?

MS MARTIN-COLE: Yes. I think right from the start we've actually wanted to engage with them and actually have conversations literally across the table so we make time to visit with them at least once or twice a year if we can get there. We were told that, you know, to access the medical clinic and talk to the GPs you best take lunch and, you know, make a bit of a fuss about it. By the second visit they were buying us lunch.

PROF WHITEFORD: You had something they didn't.

MS MARTIN-COLE: Yes. Look, could you please deliver an in-service for us. We want to understand more about, you know, what is sleep hygiene versus sleep therapy? Like, how do we actually understand that? Why do we send you people, they don't get better? You know, we can have those conversations with them. The same with the paediatric clinics and the other services. We actually have to communicate with them. I occasionally come across a GP that

is very anti-psychology and other services that are and they usually come around once we explain what we do and don't do and the same in schools, yes.

MS ABRAMSON: Thank you, Tracey.

PROF WHITEFORD: So just to finish off on that. So it's a personal communication that seems to be very important and an education thing about the role of psychology where general practitioners perhaps just didn't understand it as they should have.

MS MARTIN-COLE: Absolutely and Mental Health Professional Network meetings have been invaluable for that as well where we actually get to communicate and network. They're actually nationally funded and that's very - a lot of it's done in our own time and it's not - you know, it's not billable time and so we have to really make quite a concerted effort after hours as well.

PROF WHITEFORD: Sorry, I know you need to go and we need to move on but one last question. Maybe there's a component of the client-base you see who might access paediatric services and child psychiatry services and need access to hospital inpatient beds; is that an issue for you in the lack of those beds?

MS MARTIN-COLE: Not just inpatient beds but also youth at risk of homelessness, you know, even at 12 and 13 due to complex intergenerational trauma, drug and alcohol use of the parents, and so I think it's not just inpatient units. Certainly the research overseas has shown that that reduces or the need for that reduces but we don't have any, that's the reality and so, yes - I worked in CAMHS in 2008 and they were talking about it then and they are still talking about it.

PROF WHITEFORD: And so your team works with CAMHS still for that specialist mental health - - -

MS MARTIN-COLE: Yes, we do actually co-manage occasionally where it's appropriate to do so, yes, because we have a clinical team and theirs is more acute crisis and intervention.

MS ABRAMSON: That has been incredibly helpful. Thank you so much for making the time to come today.

MS MARTIN-COLE: Can I just say I really am concerned, you know, about some of the limitations in the access to our services in our rural/remote communities if areas of practice endorsement get used to actually have a stepped - - -

MS ABRAMSON: We might need to understand this a bit more.

MS MARTIN-COLE: I need to probably put that in a submission.

MS ABRAMSON: Well, no, we've actually got some team members here and we would welcome having a further conversation with you about that.

MS MARTIN-COLE: Okay, thank you very much for the time.

MS ABRAMSON: Thank you.

PROF WHITEFORD: Thanks, Tracey.

MS ABRAMSON: Could I please ask Ms Ross. If you'd be kind enough to say who you are and in what capacity you are speaking.

MS ROSS: Thank you, Julie. Thank you, Harvey. My name is Pippa Ross. I'm here as an individual, someone who has been through the mental health, and I'm putting that in inverted commas, pathway for many years since my early twenties when I experienced deep hopeless, despair and confusion. That was when I first started having counselling. I was fortunate to find an excellent psychologist who set a standard for all the other counselling I have received. He never gave me a diagnosis. He treated me as a person who needed to be told the truth, who needed to be listened to, respected and believed in.

I saw him weekly, at times twice weekly, and I paid for every visit because I had the means to. I was extremely fortunate. I wasn't working most of that time or was sometimes working part time but I was able to live with my parents so paying no rent and I had a bequest from a great aunt that enabled me to just make ends meet. I saw him twice weekly - sorry, I saw him weekly, at times twice weekly, and he also held human relations groups once a week. There was a lot of support and knowledge through those and I needed every bit of it.

Invariably participants in the human relations group would say, 'If only this was taught in schools'. These were adults who had already endured all sorts of relationship breakdowns and distresses in their lives. I continued my emotional wellbeing journey into the harrowing recovering of memories of sexual abuse much later in my life that had been totally buried. I have supported friends and family through both small crises and ongoing mental health problems.

Now, this is just a small request but I feel the whole concept of mental health needs to be reframed. It seems that we are approaching the issue from the acute end where human distress, trauma and relationship ruptures have been left untreated and already become a medical problem. By 'relationship ruptures' I mean everything from the lack of attachment of an infant with its primary carer, being bullied at school, being brought up in a violent home, fleeing persecution or war, to be introduced to alcohol or drugs early on in an unsupervised and uncared for situation, being homeless through lack of family support, trauma or enduring sexual assault et cetera et cetera.

We all understand the words 'emotional distress' but we recoil at the words, and I do too, 'mental illness' and I've never used that word for myself. I will just say 'emotional distress'. I feel because we use the words 'mental illness' and it's confronting, this is why mental health is not an attractive field to raise money for, to talk about openly or as we've heard here for nurses to work in. Mental health is not brain health, it is being able to maintain satisfying and relatively peaceful relationships. It's about having hope and the ability to hope for a future for one self. It's about being able to love and be loved. It is about having meaningful work or pastimes or participation in society. The word 'mental health' implies there is health and there is sickness and some are unlucky to fall ill with mental health when in fact we're all vulnerable

to it if we have trauma or serious relationship breakdowns or illness, through so many causes.

The so-called mental health landscape to me looks like a blackened landscape we've seen recently on our TV screens after the bushfires where emergency services are doing an amazing job keeping people alive. Same with mental health; we've heard at these hearings about people doing amazing things to help those at the acute end but we need to take care of the whole area of relational health way before it is domestic violence, severe drug and alcohol abuse, addiction, homelessness or suicide. We're treating the symptom and not the cause. All these are the result of untreated trauma or distress, inability to communicate, isolation, failure to build self-esteem and other relational problems. These are relational problems and not medical ones.

What emotionally distressed people need is to feel safe, to be listened to, to be respected, to be understood and to have company. Loneliness and social isolation is a huge part of being emotionally stressed or unwell. When we're emotionally fragile we need to be with people who are well, who aren't strung out themselves, who aren't fighting their own demons. Putting emotionally distressed people into group homes with other distressed people doesn't work I feel. I've heard the phrase 'community-based mental health services' and I'm not quite sure what they are exactly. If this means putting people with mental illness together into group homes with a supervisor or people living in group accommodation without a supervisor, my question is, what are we thinking?

Through my church in Brunswick, Melbourne, 15 years ago we visited rooming houses where there was no supervisor, 20 or so men in a large old house all with drug, alcohol, gambling problems, some fresh out of gaol and of course some we didn't know what their problems were or most of them we didn't. Some houses were for women only. A roof over their heads, yes. Support, no. Safe, not really. Chance of rehabilitation, probably nil. They wouldn't have appeared in the homelessness statistics but the truth is it was only one step up from the street. In fact, maybe more lonely since most of the residents didn't communicate with each other out of fear and self-protection. We would turn up with simple meals and residents would come out of their rooms, take their food and return to their rooms with barely even a word to ourselves or each other.

Also in Brunswick there was, and still is, a supported residential service. SRSs are privately operated businesses which determined their own fee structure and the services they provide. I visited a man there with psychiatric problems and I found the place chaotic and distressing. He would just stay in his room. The place houses 20 residents all on pensions all with huge problems. I talked to the staff there last week and was told there are no activities at present. I personally don't think there ever have been activities for the residents, basically it's just a roof and food. I would often see distressed residents walking the streets. I know that when we're in deep distress we need safety, calmness, kindness, help with daily tasks like food. We need an asylum in the true sense of the word. Loneliness and isolation is a huge part of being emotionally distressed or unwell.

Emergency departments or the street are no places for people when they're in that situation which brings me to a solution that is practiced in various countries of the world and one place unbelievably for over 600 years but the others since the 1950s. Belgium, Canada, United States, France, Sweden and possibly more countries all practice a system of supporting and

even rehabilitating psychiatric patients by placing them with ordinary families or foster homes. The town of Geel, I'm not sure if that's the right way to pronounce it, in Belgium is the oldest and it allocates people sometimes with schizophrenia or who have had psychosis to a couple or a family where they live as a member of that family joining in the activities as they are able, contributing to the running of the home.

In 2018 there were 205 boarders living in Geel. Geel's medical professional will say the system makes a lot of sense. Boarders have better outcomes than patients in hospital, they take less medication and have few acute episodes said someone who works in that area. A group of therapists and nurses support the household, the host and the guest with 24-hour access - ignore?

MS ABRAMSON: Yes, ignore it. Lisa's come to the rescue.

MS MARTIN-COLE: Okay, I'll take that opportunity, I'm getting a bit dry. I'll start again. A group of therapists and nurses support the household, the host and the guest with 24-hour access to health if needed. The guest receives therapy from the support team but in the home the person is just treated as a guest where their host may have – will have no idea of any diagnosis. And hosts aren't trained in psychiatric care.

The guests are assigned a family after being assessed in a hospital and after any acute psychotic or schizophrenic episode has finished. Any guest with a history of violence or abuse of others, of course, wouldn't be eligible. The hosts are paid an allowance which is way below the cost of an acute hospital bed and below the cost of community care.

Under the Swedish scheme called Family Care Foundation, residents might stay for several months or a year or two, all the while supported by regular counsel and therapy. The aim is not to diagnose and label, but to treat each person as someone who needs love, care, support, stability and peace and most of all, company.

Sometimes our family of origin is not the best able to help us when we have a mental illness. Now, I just want to talk, if I can about the medical model versus community model. Mental health can be viewed as a medical problem that only GPs and medical specialists know how to fix.

Or it could be seen as a relational problem that untrained people can help with. It can be seen as a field for experts or it can be seen as a field where the person suffering can be helped to work out what they need.

The alcoholics anonymous model which I don't have direct experience of, but I know various people who have. The AA model has been successful for so many years around the world, because it's centred on relationships as a pathway to healing. Relationships within the group, the sharing of common experiences, sharing of knowledge about alcoholism, observing those who have broken free of addiction and also the close sponsor role where someone who has been sober for years takes a new member under their wing and is available. Sometimes 24 hours to listen, to talk and support.

I have been to peer led residential retreats through Heal for Life in New South Wales for those who've suffered childhood trauma. I could find no one else in the country who's doing such cutting edge therapy or offering such profound help that is available there.

I sometimes thought myself that if I'd had a drug or alcohol problem I would have received much more help and support that is, through AA or just the supports that are out there. But having depression and anxiety and low self-esteem didn't warrant such help. I felt invisible. The medical model also sees that nursing trained infant welfare sisters are the ones to manage the early years of humans being – of a human being's life, (with the mother of course, or parent.) They have very little training in giving psychological and relational help to mothers. In those early crucial years, a child has been seen as someone who can be attended to solely by the medical profession. Maybe there is need for more peer support and again to bring this outer medical model of dealing with human beings.

The idea of infants being assessed for mental health problems gives me the heebie-jeebies. Give mums the proper support they need before they take the baby home and you might be part-way towards having good outcomes. So many mums I know have had a very difficult time after being discharged from hospital two days after giving birth before even breastfeeding is established. Before they have overcome the drama of birth. Before they have been able to catch up on a bit of sleep.

I can't imagine being assessed by inadequately trained or inexperienced people with a rudimentary knowledge of depression. Already anecdotally, infant welfare sisters are looking for depression behind every bush whereas in the past, everyone new that mood change is a normal part after a significant event such as birth. Infant welfare nurses need far more extensive training in psychological and social development of a young child and how to help families, especially in crisis.

Young women now often have very little contact with infants, toddlers or even children. They have full-time jobs before giving birth. An infant welfare sister I know here in Tasmania said yesterday that 'Loneliness and isolation for new mothers is a big problem since they have often been working up until the birth and have no – may have no family support. Maybe that's another opportunity for non-professional peer support.

Grandmothers for generations know how much a new mother needs support, company, feeding, rest as she eases into the new role of mothering an infant. There needs to be so much support in those first days and weeks after birth. I'm not sure whether short stays in hospital after birth are due to funding constraints but everyone needs the opportunity to have a longer stay especially if they have no support at home.

I have supported family members myself in the last few years. One with a partner, one without. Both were at crisis point after being released from hospital and assuming they could do it on their own. Thank goodness they asked for help. And after that, they were fine. I'm going on, is that okay?

MS ABRAMSON: We're at time.

MS ROSS: Right.

MS ABRAMSON: But if there's something in particular that you want to say, please. We just won't ask questions, that's all.

MS ROSS: Okay. Well, I really believe that we – I don't agree that schools are too pressed to introduce relation and wellbeing into the classroom. Schools aren't too busy to do drug education, sex education, the topic of bullying, different sexual orientations. I'm trying to precis it. Drug education at present starts in primary school. There's no point teaching children the dangers of drugs if most drug and alcohol addiction is underpinned by trauma and distress.

Sex Ed is taught in schools. No point in teaching it without teaching more about relationships. Bullying is a huge problem and most schools seem to be grappling with it. It's a bit late to ask a mate how to express how he is going at 40 years old when his wife may have already left and he may be alienated from his children. Better to get him to talk about himself as a child or a teenager. And just a couple more points. I think the cost of individual therapy is outrageous.

How on God's green earth can anyone justify charging \$300 a consultation for 50 minutes as some psychiatrists do. Again, group therapy is a cheaper alternative or as an adjunct, but it's often not talked about or I don't think there's enough available. I do not believe GP's are equipped to manage mental health care plans. They are trained in the most rudimentary elements of mental health as a previous speaker in these hearings, I think he was a psychiatrist, stated.

Another GP, another speaker, a GP claimed her job in matching patients with their therapists is like being a matchmaker. I feel she is unique. She understands it is a good therapeutic relationship that can bring healing or at least comfort and maintain stability. GPs don't have the time or information to match a patient with a therapist or counsellor. They also may not have the interest or knowledge required.

Many people are unaware that a patient can find their own therapist and then ask for a mental health care plan. For years, we had hoped for subsidised mental health, but it has backfired in some ways, I believe. Ten sessions is not long enough to find a therapist you get on with. Some you won't and never will, so that might waste two or three of the sessions, then you've got seven or eight sessions to get to the bottom of the problem. So counsellors are rushing through to get patients sorted in 10 sessions because now there is this expectation you will get your problem sorted in 10 sessions. When I don't think that's ever been the view of psych – therapists in private practice.

I know friends with severe trauma in their background who have been assigned to – through their GP – to psychologists in their area, in their country town. These friends were – this friend was – one of the friends was not willing to allow me to share the details of her trauma, but no one would argue that she didn't need long and protracted support. This psychologist told her to practice mindfulness and another one said, 'Sit in the sun and listen to the birds.

Which brings me – I'll just finish now, if you like – to accountability. There's no accountability for the GP referrals. No accountability even for psychiatrists. I think it's incredibly hard to complain about a treatment at the hands of a psychiatrist. And I think most people just don't bother. In – I'm talking about private practice - well, also public health.

I have a young man who's come to stay with me and he had – he had severe alcoholism for the last five years and he went to detox several times and he had to be admitted under a psychiatrist. He said that psychiatrist would spend the maximum of 10 minutes with him at each talk he had while he was there. And he just said, 'There's nothing wrong with you,' and 'Just keep exercising.' And also suggested he join the local tennis club. This man was drinking himself to death.

He came to stay with me because I have listened that model of - I've been very touched by that model of taking people into the home and loving and caring. He came to stay with me on my farm and after a while he opened up about a trauma that he had never told anybody about that had happened to him when he was ten and since then he's given up drinking and he doesn't take Seroquel which he was also prescribed by the psychiatrist which he doesn't even know why he was prescribed it because he's never been diagnosed with schizophrenia or any of the other things that apparently Seroquel treats. So I guess basically I'm just asking for more seeing mental health as a relational issue that can be addressed way before it gets out of control.

MS ABRAMSON: No, look, thank you very much. That was a very eloquent presentation.

MS ROSS: Thank you.

MS ABRAMSON: And thank you for your previous submission. We really would welcome another submission particularly about the examples you've given from overseas.

MS ROSS: Yes.

MS ABRAMSON: But thank you very much for sharing your experience and also having a very constructive view about what we could do so thank you very much.

MS ROSS: Thank you.

PROF WHITEFORD: Thank you.

MS ABRAMSON: Thanks. Could I please ask the next participant, Ms Oakley-Lohm, I hope I've pronounced it properly. If you'd be kind enough to announce who you are and in what capacity you're appearing. Thank you.

MS OAKLEY-LOHM: Hi, I'm Jane Oakley-Lohm from Balancing of Life Counselling. Firstly, I'd just like to thank everybody; the Commission and yourself, Harvey and Julie, and the team for coming to little Launceston. It's much appreciated. Okay, a little bit about myself. It's quite diverse my background. I've been living in Tasmania for ten years but previously I lived in central Australia. So I do want to bring the attention to everybody in the room, including yourselves, the issues that are in central Australia and not just central Australia but rural and remote.

Having lived there in remote areas myself plus Alice Springs and working remote there is such a lack of service with today's mental health scheme. So I'm just going to give you a little bit

of an example. To begin with I guess my qualifications, if you would like to know, I am a counsellor, a clinical supervisor, a mediator, a project manager and assessor for trainee counsellors.

MS ABRAMSON: You're very busy by the sound of it.

MS OAKLEY-LOHM: Well, this is the past. In Tasmania we take a step back and breathe a little bit of the fresh air. The other thing that I have done in Tasmania has worked with long term unemployed people and I just want to - in a counselling role - and I just want to point out that for some people in Tasmania there is five generations of unemployed, that is a lot of issues with mental health. These people can't afford to go to a doctor, to get onto the mental health plan and then can't afford - if there is an out-of-pocket fee they can't afford it.

With the present mental health system there's many people that can't access the service and I just want to go over a few places. Farmers, they often have to travel at least one hour to get to a doctor. Doctors in small communities often have a wait time. Then there's an extra wait time to see a psychologist. Outback stations, they might travel five to nine hours to get to a small town and then of course they've got the same wait time. All these people that travel from an outback area to get into a town there is a cost. There's also no one to take their place on the station or the farm or the roadhouse or the Aboriginal community to replace them in their job so therefore they're pressured often not to go by their employer or their own self.

We have - don't forget all the tourist locations that are remote. How many employees are on the islands of Australia and Ayers Rock Resort et cetera et cetera, there's no way they can get easily to a doctor to get onto the mental health process. Rangers and their families live on remote areas, the same process there again. So I don't feel the system that we have today actually assists these people. Being a counsellor, and I do take onboard what you said before, sometimes we are looking at mental health the wrong way around. We're looking at, 'Let's provide a service for these people with extreme conditions here'. What about the people that are just coming through with issues, let's not get them to those extremes, let's help them now and I do feel there's a role for counsellors to do this.

Another example of how counsellors can help. I'll give you an example of what I did in central Australia. There is a lack of psychologists naturally and psychiatrists in Alice Springs and when we're talking Alice Springs mental health we're talking of the health region which is one million square kilometres. There's not many services out there and those people have to travel to get any help. So therefore the Mental Health Association of Central Australia actually saw this as a problem and contracted my business to come in and float with their clients more on a day to day system. So they could come in for a chat at any time and we would go through whatever was their issue for today.

Now, often they couldn't get in to see a psychiatrist maybe twice a year, once a year if they're lucky. Their psychologist a little bit more often but it was still extreme. Now, people with mental health issues can go up and down, up and down, up and down very quickly and go off medication, there's a crisis in their life. People in the outback areas don't necessarily have support from family and friends, they're isolated. So therefore what I'm saying is we need a system in place, and I feel this is the role for counsellors, that can help monitor them until they can get in to see a psychologist on the mental health program.

In Tasmania here on the north-west there's up to a four month waiting list to get in to see a psychologist on the mental health program. These people need help now. Yes, they still may need to get to the psychologist but let's give them some support which I feel counsellors can do to get them there. Because I'm so passionate about this and having now lived in central Australia for 30 years I've come away thinking, 'What else can I do?' I'd like to point out that today Telstra have provided a landline into all these areas; roadhouses, Aboriginal communities, stations, tourist complexes, they do have a landline.

So what I've started up with a group of counsellors from all over Australia is an online service. We're brand new, we have no funding and we now can provide a service seven days a week including out of hours. Some of our counsellors are providing a service till midnight and 1 am. There is a small cost involved because we don't have any assistance with this. We have kept the cost down because we are all working from home so at the moment people can access us between \$60-\$80. I do understand that with - and I'm not bagging out psychologists here, please don't get that opinion at all, we're all needed - some out-of-pocket expenses for psychologists today in Tasmania is up to \$80. There's a lot of people that can't afford that definitely.

We can take on, Balancing of Life Counsellors that does provide the service, we can take a client today but getting this information out to rural and remote areas is very difficult and I feel we need some assistance to do that. If there was some sort of support with counsellors being involved on the mental health scheme this would be fantastic. It would mean it would be a totally free service going out to rural and remote locations. And also in Australia in these big towns there's a lot of people with disabilities that their work career says, 'You don't have time to get off work to go see a counsellor', there's travel components, there's single families that can't get time out. They can put their kids into bed at night and can get on the phone to a counsellor at ten o'clock at night if they want.

PROF WHITEFORD: Sorry, can I just interrupt and ask the \$60-\$80 you mentioned, is that per session?

MS MARTIN-COLE: Per session, yes. It's an hour session.

PROF WHITEFORD: Yes.

MS MARTIN-COLE: The difference between us and an emergency service - an emergency service, for an example, Lifeline, a brilliant service, absolutely. They can talk to a client - it's around 30 minutes because it's an emergency line but that client can't pick up that phone again and talk to that same counsellor so therefore they need to repeat their story but with us they can pick up the phone and speak to that same counsellor.

I've done a quick research in the UK and I could be wrong but this is my understanding, that in the UK to access a psychologist they get a referral from the doctor. The community can access a counsellor without a referral and it's still covered by their mental health program, that's my understanding. That would be great to have here. So therefore the counsellors can help monitor the clients until they can get into the psychologists. If we're getting them early enough they may not all have to go to a psychologist. That has to help with funding all round.

The counsellors that are onboard with the Balancing of Life counselling are all Australian accredited, they're all insured and they all belong to a counselling body here in Australia which ensures they have ongoing training and supervision. Supervision at the moment is done by me so therefore if we are providing a service to rural and remote locations I do have 30 years' experience of helping them to deal with these people living in outback areas and if we do have this service going to outback areas we do need to have clinical supervisors that understand what's going on.

So I guess, (1) any questions? But (2), I do feel we have got a solution here. That can be picked up tomorrow. I can get heaps more counsellors onboard within a month to help provide this service. I was speaking to an Aboriginal counsellor only yesterday and she's from the east coast, she would also love to come onboard. You know, I feel can we take more onboard until we can get this word out, you know. I would love to see more central Australian Aboriginal counsellors come onboard.

And there is this opinion that Aboriginals must speak to an Aboriginal counsellor is, not necessarily true. Now, the reason for me saying this: I was employed some time ago to do a grief and loss project in the mental health region of central Australia. Now, that was run through Northern Territory government and La Trove University of Melbourne. Now, what I did in that project was to look at what is going on in central Australia. The amount of suicides is horrendous.

So I had to look at what is grief and loss for these people, do they have a tool, is that tool still accessible and if not what do they want? What I learnt from that is: (1) there's 26 language groups in central Australia of Aboriginals before you go into any other cultures. They all work through grief and loss differently. If we look at traditional cultures of the world they all talk about grief and loss openly. They never talk about depression. Our western community waits until we're all diagnosed with depression before we talk openly about grief and loss and I feel counsellors can help in that role. If we're not dealing with day to day grief and loss and giving them that support we're having compounding grief and loss which can turn into depression.

MS ABRAMSON: Harvey.

PROF WHITEFORD: No, I'm fine.

MS ABRAMSON: I just wanted to ask one question about your experience in Alice Springs and that is we were told there was a lack of coordination and integration between services and that was a big problem. I'm just wondering if you have any views on that and how it could be improved?

MS MARTIN-COLE: Okay, I haven't lived in Alice Springs for ten years but my passion definitely is still there. I can't give you the up to date details on that. At the time when I was there we definitely had meetings that you could attend but what you've got to understand when they have lack of services to begin with, for everyone to leave their job and go to these meetings about all the services there's no one behind here doing their job. They are bogged down.

So another project I did in central Australia was providing training or coordinating training to

all remote areas of central Australia in aged care centres and what we did - part of that project was to provide funding for people to leave their jobs so they could attend training and that is what's needed.

MS ABRAMSON: We've understood that point in the context of training or early childhood workers who have actually said one of the biggest issues is who does their job when they're attending (indistinct words).

MS MARTIN-COLE: Exactly.

MS ABRAMSON: Thank you very much for your presentation.

MS MARTIN-COLE: Okay, good.

MS ABRAMSON: We will have a short break until 10.50 at which time we'll resume and it looks like there's coffee and tea at the end of the room; is that right? Yes, the team are nodding. Thank you very much.

SHORT ADJOURNMENT

RESUMED

MS ABRAMSON: Thank you, we'll reconvene. We have on the phone, I hope that you can hear me, Diana Kube and, Diana, if you'd be good enough to announce who you are and in what capacity you're appearing. And we've got the mike here right for the transcript, that's the other thing if I could mention to people, the mikes are actually just for the transcript, they're not amplifying. Can you hear me, Diana?

MS KUBE: Yes, can you hear me, Lisa.

MS ABRAMSON: It's Julie, I can hear you. I'm not sure if other people in the room can but we'll do our best.

MS KUBE: Okay, I can speak up if you like. Is that better, Julie?

MS ABRAMSON: Yes, thanks.

MS KUBE: Okay, my name's Diana. I am a counsellor with postgraduate qualifications. I work in family violence and family and relationships counselling. I also do adjustment counselling for people with disability who have to adjust to disability in return to work programs. So I've been involved in the counselling space for a number of years and I am a bit concerned about some of the things I see happening including the corporatisation of the mental health space and the increasing devaluing of people with counselling qualifications in favour of people with social work and psychology qualifications where people with counselling qualifications are generally holders of postgraduate qualifications. Those are the issues that

I am finding a little bit disturbing because what happens is that as a counsellor I am unable to provide services that are covered by a mental health plan and by private health insurance. This is of concern because it increases demand on private psychologists who often have waiting lists of up to two or three months and are only able to see clients about once a month so it is a very changing space and I think that some of the changes are not as productive as they could be to ensure a high quality of mental health service provision.

MS ABRAMSON: Thank you. Look, I have to apologise for the people in the room, we've got the phone at maximum volume and I know it's very hard to hear. I'm just interested in your views, you said about counsellors providing more support which I understand from other arguments is about a Medicare rebate item but what are the other ways in which you think that the counselling workforce could be better utilised?

MS KUBE: I think many GPs overlook counsellors as a viable option when referring clients for counselling services. They tend to want to access psychologists whose skills are better utilised in other areas rather than general counselling so I think that that is an issue in itself. I also think that many not-for-profits are devaluing counselling staff in favour of employing psychologists and social workers where if you're wanting someone to provide counselling services why aren't you hiring a counsellor?

MS ABRAMSON: I'll just ask my colleague, Professor Whiteford, if he has any questions.

PROF WHITEFORD: Thanks, Diana. So you may or may not have seen the stepped care model that we have included in the draft report. On that continuum of care the role and the place for psychologists versus counsellors; is there an overlap or do you see there's more a discrete role for both within the stepped care approach?

MS KUBE: I think there's a distinct role for both. I think that when you're talking about delivery of services to specifically women perhaps impacted by domestic violence it may be better served by, you know, sending those people to a counsellor for a start. If you have someone with mental health issues that are significant, long term and ongoing then perhaps a psychologist or a psychiatric referral is more relevant to that person.

PROF WHITEFORD: Yes, okay, thank you.

MS ABRAMSON: I just had a general question about child and family support services and this morning we had some conversations about the lack of inpatient beds for adolescents so I'm just interested in your views on how that adolescent mental health is being provided in Tasmania particularly with headspace if you're able to comment.

MS KUBE: I think headspace provide an excellent service. Unfortunately I think they are not able to provide the range of services that I think they would like to have and that they are not able to provide the intensity of service that they would like to. In Tasmania we do have a really significant issue with lack of mental health inpatient facilities for adolescents and these children are often having to go interstate for services where their families can't be with them and that in itself is a strain on someone with a mental health problem. I've had many clients whose parents have, you know, given up on trying to access inpatient services here and gone interstate for service and it's often complicated the issue rather than solved it.

MS ABRAMSON: Can I also ask you a question: if the view is that GPs and NGOs undervalue counsellors, what more could we do to promote the value of counsellors?

MS KUBE: I think part of that is ensuring that they can be registered to provide private health fund services so services that are covered by private health insurance and a mental health plan so that people don't feel that they have to pay a huge amount of money upfront but it also demonstrates that counsellors are valued by the community and the government.

MS ABRAMSON: One of the other things that we're being told is that GPs getting info back on services about a client has increased their appreciation of the value of services and we certainly heard that this morning in terms of the psychologist working with GPs who were initially not being particularly supportive so to what extent do counsellors provide information back to GPs when they're the referrer?

MS KUBE: The referrer, we also seek - well, I specifically always seek the client's consent to report back to the GP but I do like to provide a service that is a holistic service so that GPs, schools and other key stakeholders are involved but I can only do that at the discretion of the client.

MS ABRAMSON: Harvey?

PROF WHITEFORD: No, that's fine.

MS ABRAMSON: Thank you very much. I'm sorry that the technology hasn't been as great as we'd hoped for but thanks for persevering with us and for making the time, thanks very much.

MS KUBE: Thank you.

MS ABRAMSON: I do apologise for that. Now, our next person we have is Mr Asten. If you'd be kind enough to state your name and the capacity in which you appear. And I also invite you to make an opening statement should you wish to do so.

MR ASTEN: Thank you. Yes, I would please. Is that in the right place? Is that okay?

MS ABRAMSON: He comes and moves it if it isn't, he's pretty - - -

MR ASTEN: Good, thank you. My name is David Asten. I live in New Town, Tasmania. I'm here to put my concerns to the Productivity Commissioners and thank you for the opportunity of coming along. I've got three key points in support of a national database of mental health orders. Now, mental health orders as you'll be aware are not for the everyday mental health patient but for those with severe mental illness who need some support, some direction, some - yes, support and direction not necessarily that they volunteer for.

So three key points. A case study that I'm very familiar with; personal experience of something else that's possible; and a plea for leadership and improvement in mental health administration between the states and territories of Australia. Now, the phone rang years ago and I stirred. It

was 1:30 in the morning. My wife grumbled. It wasn't a nuisance call but a call that was to highlight a shameful gap in Australia's legal systems concerning mental health, a shameful gap in Australia's ability to look after its own.

There is plenty of publicity for the boat people and others that come to Australian shores looking for refuge but there's very little action or publicity for those Australians with severe mental illness. And thirdly, a shameful gap between the Australian states in how they manage mental illness and that gap constitutes neglect in many instances and then allows for abuse of Australian citizens with mental illnesses.

So let me go back to that phone call at 1:30 in the morning. Our loved one needed money to pay the taxi driver and my question was, 'Oh, whereabouts are you?', 'Oh, I'm in St Kilda', 'Oh I thought you were at the Royal Hobart Hospital?', 'No, I'm sick of that place. I needed to get out'. And that was the start of a bit of a story about how our loved one had managed to get through a locked door and escape as it were and eventually a day later turned up in Melbourne and it's really the start of a story and an example of neglect between states and the potential for abuse then because as you'll hear shortly in Hobart I rang the Royal Hobart Hospital and those in charge of the psychiatric ward said, 'Oh, thank you for letting me know. We'll cancel the mental health order. Good luck'.

I rang the mental health administration, 'No, can't follow-up, she's outside our jurisdiction' and because this particular person I'd corresponded with often he said very quietly, 'My manager would cane me if I rang Victoria about this and I've got a heap of jobs on my desk that I'm yet to attend to'. For our family there were then followed two visits to Melbourne to catch up with our loved one because for better or for worse she kept ringing us because she was short of money and when we met she was under the close supervision of the manager of a half star boarding house in St Kilda and the manager said, 'She needs more money'.

I went to the Victorian Police, 'No record of your loved one here, she's over 18, low priority for us'. Went to the mental health department for Victoria, 'No records here, no reason to check up' and my impression was that the person concerned thought parents were fussing too much about an adult child. We kept on trying to do what we could and two months later I managed to talk to a young constable in the St Kilda Police Station and she listened and not long afterwards our loved one was transferred to St Vincent's Hospital. Now, with two months of neglect her state of health was most unwell and it took two months in hospital of intensive treatment to restore the balance and be ready for discharge but then St Vincent's Hospital said, 'We haven't anywhere to send her. What are you going to do?' So there were more phone calls for me in Hobart and eventually I got through to a deputy secretary for health and I went to see this person and she conceded rather reluctantly that this person was Tasmanian, we ought to take her back.

The followed prolonged but volatile time in the Royal Hobart Hospital the mental health order was renewed, our loved one had time in the psychiatric intensive care unit, even time in the forensic mental health unit and today I'm very happy to say our loved one's a different and lovable person because she has medical supervision and medication taken each day and it makes a world of difference. But it's not only a world of difference for her and for us as family, it's a very big change for the mental health staff, even the police, because at the moment as back then when someone becomes ill in the community the police are involved and the police

can't leave this person until the hospital take charge.

Now, the Royal Hobart Hospital and the Launceston General Hospital have got queues of ambulances waiting and so people with mental illnesses don't get - because they haven't got a broken leg, they haven't had a heart attack or a stroke, they don't get first cab off the rank in the hospital and so the police are tied up for a considerable time. It's been reported in Hobart that the police can be there for four/six even eight hours waiting for their client - their person to be admitted and looked after appropriately in A&E so here I see a great potential for productivity improvement and that can come about because if states cooperate with each other and recognise for instance that a mental health order in Tasmania should get the same priority as a mental health order in Victoria and vice versa.

Now, I said earlier that I had a second point about personal experience and it goes back a few years and it concerns a family wedding. Now, that might sound strange in this context but my wife and I stayed overnight in Melbourne because the wedding was up near Albury. I left the hotel next day, I drove up one of the Melbourne streets and I got in the wrong lane and while I manoeuvred back into where I needed to go the lights flashed behind me and the young traffic policeman wanted to ask me what I was up to. My driver's licence was taken away for a few minutes and he came back and he said, 'Mr Asten, I see you had a speeding fine three years ago and a couple of minor incidents in earlier years. You're here for a family wedding? Well, take care, respect our road rules and enjoy your holiday'.

And there was a system that makes state-based drivers licence records available to every police force in the country. Why can't we have something similar for mental health orders? What's the matter where they are senior clinicians and senior public servants that they can't see that there is scope for a great productivity improvement if those systems are recognised between states? Because I know from experience and I know from talking with others that prolonged time without treatment for a person with mental illness means a long time to recovery, sometimes prolonged damage. So there is every reason in the world for Australia to bang a few public servant heads together and say, 'Get this right between states'.

Now, my recommendation is that there be a national database for mental health orders. A database like the drivers licence one is accessible to every police force in the state, accessible to all the major hospitals and that improvement in productivity will please the treasurers in each state but that's only half because what's really important is that the person concerned will not suffer the same level of illness and prolonged disability that goes with this type of mental illness and their families will benefit, their friends will benefit, the community will benefit, even the police force will applaud if they don't have to stay with patients who need immediate help because they've been without treatment for so long. And so for that leadership is needed. It's needed a combination of law, a combination of health and police with of course the cooperation of the state treasurers but the treasurers will benefit and I can't see why when after all these years why our political leaders don't see the value of harmonising mental health laws and treatment protocols.

MS ABRAMSON: I'm going to respond a little bit to that before you get to your next point. It's a really important point that you've made. I mean, I'll be honest, I haven't really thought about that. The only possible answer is because the Mental Health Acts are all state in nature they've all got different quirks and are slightly different but it seems to me there are two issues

in what you're talking about. The first one is an action of national register around actual orders made by mental health tribunals. The second issue we're having another look at is the data right or a consumer right to their own records and My Health Record, as far as I'm aware, Harvey, is a national-based service. It may not be as supportive for you as family, your access to those things, but it's a really important point. I don't know if you know much about the mental health orders and whether they're recognised interstate, Harvey?

PROF WHITEFORD: So the orders are supposed to have transferral capacity so that if you need to be transferred from one state to another you could be transferred seamlessly under the different jurisdictional orders but your point is if you were under an order in one state and you turn you up in another state, as your loved one did, there's be no way at present of knowing that person had been under the Act and that sharing of information, I guess if we have to jump through the privacy hurdles, but I suppose your point would be if it's there for road traffic offences, perhaps something more important about protecting lives.

MS ABRAMSON: It's interesting, we will all have a very good look at that because I even think that the fact that it is a public record might mean that some of the privacy concerns have already been dealt with. We'll have a look at it, it's a really important point.

MR ASTEN: Good.

MS ABRAMSON: And I interrupted you, you were going to make another point to us.

MR ASTEN: No, I'd come to the end of my prepared part but I'd be - I mean, you talked about people in the past and I think back to Cornelia Rau. Now, Cornelia Rau was a resident - in fact she was a Qantas air hostess about 15 years ago, became unwell, moved from Sydney to Queensland, became even less well, and was arrested by the police and because perhaps of her family background she was thought to be an illegal immigrant and she ended up being put in a detention centre in South Australia and it was quite some time before a regular visitor was a bit puzzled and started to ask questions and dig and it was found she was an Australian resident. Yes, with a bit of an accent as there are many people in Australia and if you look at her website you'll see that not everything has gone right for her since but an example of the kinds of things that happen when people go interstate and there are very few that have publicity because of the contacts that I have, family shy away from exposing their loved ones to the public eye.

MS ABRAMSON: But the corollary answer to that is when you're talking about the licence, there are very strict protocols around police as to who can access what on a public database so those are things that - I mean, I'm just thinking out loud - you could build the right type of protections in them.

MR ASTEN: If drivers licences can be accessible to every police station in the country then surely there would be a - the police would have some protocols for certain categories of Australian citizens. For instance, I'm quite sure that there would be a special register for federal politicians. They would be dealt differently from me probably in a number of respects.

MS ABRAMSON: No, it's a really important point, we'll have another look at this. Could I ask you a different question which is being in Tasmania how easy is it to access services in other states?

MR ASTEN: We've not tried to access services in other states. We have taken our loved one on a holiday to Queensland in the intervening period but we sought that out with the Tasmanian authorities and we undertake to supervise the medication.

MS ABRAMSON: Thank you. Harvey?

PROF WHITEFORD: No, that's fine.

MS ABRAMSON: Look, that's been a really important - I mean, all of the evidence matters but this is something that we'll have a really good look at and I know you've travelled today to be with us so thank you very much for that, thank you.

MR ASTEN: That's fine. It's important not just for us but I suspect if there are 25-30 Tasmanians that escape their mental health orders each year that would be equivalent to 1000 or more across Australia, maybe 2000 and I'd ask if you don't have that statistic I'd suggest you ask the states to present that information.

MS ABRAMSON: We may have a lot of trouble getting data but what I can say we will have a look at - is because this will not be a novel problem, although it feels like it I'm sure when you've experienced, there will be a reason why - someone will have suggested this and there'll be a reason why it hasn't happened so we need to have a good hard look at that. Thank you.

MR ASTEN: Thank you.

MS ABRAMSON: Could I please ask our next participants, Ms Jones and Mr Jones from Tasmanian Life Counselling. If you'd be kind enough to state your names and also the capacity in which you appear. I was about to make the assumption which may not be accurate.

MR JONES: No, it would have been accurate. Not a problem at all.

MS ABRAMSON: Thank you.

MR JONES: So my name is David Jones. I am currently working again at a couple of different places one of which is a drug rehabilitation centre but my role here today is to really express for the case why I think counsellors should be recognised in the same way as psychologists and - well, psychologists particularly in the counselling field. Part of my experience sort of stems from - did you want to go first (indistinct words). Okay, I'll keep going. One of the first things I was taught when I transitioned from industry into counselling as a professional probably five/six years ago now was that one of the things that counsellors do is look for incongruity in the client's story and what's happening so we can actually identify where we might work with them and one of the most obvious incongruities in this industry was the fact that the counsellors as a profession aren't recognised with similar qualifications and skills as psychologists and it was like how does this even - how does it work? How does this happen? We have the same qualifications, we do a four year bachelor's degree and since then I've actually gone to try to do a Master's of Social Work degree but I've actually found it doesn't actually compound or enhance my capacity as a counsellor to operate so I'm working through it mainly so I can actually be part of the MBS process so I can actually deliver the

services that I believe are necessary here in Tasmania.

In that journey over the last four or five years I've actually worked for a couple of organisations that provided men's behaviour change programs and I've identified there's been a number of weaknesses in those areas and a number of strengths in those areas but what I've identified and most particular is we have an insufficient capacity to actually reach the majority of Tasmanians. We have a couple of programs that work out of Launceston, a couple work out of Hobart and some have worked out of Burnie but we may reach between those programs maybe two/three hundred medium to low or high risk family violence offenders in that group.

Within those groups of the guys that tend to attend those programs, you have a (indistinct) rate at probably more than 50 per cent in the first few weeks but probably what's most prominent is the fact that those that live in geographically remote areas such as St Helens or - well, pretty much anywhere that's outside the normal capital cities there's an incapacity to those individuals who often lose their licences for various reasons, there are other maybe life factors that affect their capacity to actually attend so you see a very poor take up of the service but also a very poor capacity for them to be actually benefit from the psychoeducational programs there are.

As a personal frustration for me both in that the Tasmanian counselling service and also in general is that the incapacity that I've had to actually being able to get out and actually service that market, there are very few individuals that I've come across (indistinct words) few that I've come across that actually have interest in the actual dealing with the offender side of the problem. Lots of victim services (indistinct words) work but for me prevention is actually a better tactic than cure but I believe that there is a much greater capacity for that psychoeducation program to be taken to regional centres but often funding becomes a part of that problem so I believe that if there were more counsellors available (indistinct words) to offer those kind of psychoeducational services (indistinct words) MBS process - that is, programs could actually work to combat that problem directly.

So I think that is the majority of my argument. It's men support in general is actually quite poor and I think the men that I've worked with tend to have a perception, accurate or inaccurate, that there's a kind of a scaling process that happens associated with the level of stigma that you'll be labelled with from your mates depending on the kind of service that you actually apply to so if you apply to a counsellor, that could be anything (indistinct words) problems, relationship issues, not mental health issues per se, just struggling with how to cope and actually manage day to day activities. At the moment you are actually directed towards a psychologist, which is maybe the only service that's available, you've instantly escalated then to, 'Well, I'm actually going to see a shrink' or 'I'm going to see somebody who is directly interested me having a mental health issue' and as soon as I'm labelled with a mental health issue then less likely again (indistinct words) process and if you get to the level of a psychiatrist then you're really in trouble because, you know, you're really off the deep end somewhere so whether it's accurate or an inaccurate perception I think that general stigma is still prevalent and men particular - more are accessing general health services so mental health service is an even greater struggle and I believe that giving the capacity to counsellors in those regional areas where there is more familiarity with (indistinct words) as part of the community. They're flexible, they're more local, they're easier to access, I think it makes a likelihood that they have an interest in attending a service or attending some support, it's likely to increase with locality and geographical support in mental health.

MS ABRAMSON: Can I - thank you, can I - we're well aware of the point that the counsellors have made but I'm really interested in the comments you made about psychoeducation programs; what do they look like?

MR JONES: Well, a psychoeducational program is something that actually attempts to breakdown what are essentially taken for granted activities like relationship issues might be a fundamental one and a psychoeducational program might be a three or four week program which includes things like the quality, it may include behaviour towards each other, interpersonal communication, a whole range of things which enhance that person's education skills and (indistinct words) understand what's happening around them, understanding emotion regulation so it increases their capacity to understand who they are and how they interact with other people and it's purely educational - - -

MS ABRAMSON: Is it being done mainly in schools or is it broader than that?

MR JONES: No, the Men's Behaviour Change Program is actually at a high proportion of education (indistinct words) as long as ten weeks and, yes, it's actually - there are some that are court mandated, there's a couple of court - - -

MS ABRAMSON: Yes, I'm really interested in hearing a bit more about the forensic side of it because I can imagine as part of an order that people are mandated to do this course and then the difficulty is, especially if you're in rural and regional Australia, where is the course actually being run and you very eloquently said it could be difficult to get there so I'm just interested in how much of those type of programs you do?

MR JONES: Well, I'd like to do a lot more.

MS ABRAMSON: Yes, yes.

MR JONES: But as I no longer, and this is perhaps one of the issues here, is I no longer work for either of the organisations, one of which I helped design the program and the other one which they have a program that's already in place. Whilst I was working for those organisations I was qualified to be able to deliver the program and even create the program. On needing those programs - - -

MS ABRAMSON: Were they supported by the health department or justice or?

MR JONES: Part of the Safe Home, Safe Families - - -

MS ABRAMSON: Okay, that was a Tasmanian program?

MR JONES: Yes, Tasmanian program, two Tasmanian programs.

MS ABRAMSON: Yes.

MR JONES: But you're absolutely right in terms of the family violence offender intervention program which is a mandated program from the courts for the medium to high risk offender,

you may start with 15 people of which some may be from regional areas because they've got a lift in or they've got something to do - - -

MS ABRAMSON: So it's done as a group therapy type - - -

MR JONES: It's a group therapy environment. But often you would end up with individuals not completing that mandatory aspect of their order, their 12 months would expire and they've never actually attended even a single session simply because it isn't possible for them to get to the program itself and there's a kind of little bit of a (indistinct words) attitude towards that saying, 'What can we do without taking a bus out there to collect them?' The bus services from regional Tasmania are quite notoriously poor in terms of their timing so finding the flexibility to deliver those courses where they are - I mean, I'm sure it's been considered but certainly there's this attitude, 'Well, look, they just kind of fall between the cracks' never having (indistinct words) and we haven't really served the public interest in terms of protecting the individuals or enhancing the safety of these individuals (indistinct) they may have impacted against (indistinct) so there's a big huge gap that - - -

MS ABRAMSON: Thank you. Harvey?

PROF WHITEFORD: Sally, did you want to?

MS JONES: Yes, I've got a different angle.

PROF WHITEFORD: Okay, let's give you a chance.

MS JONES: Thanks. I'm also a qualified counsellor with over 20 years' experience. I've all university degrees and a PhD candidate at the moment and I find it quite frustrating with my experience that I'm not recognised as a mental health professional and quite frequently come up against the barrier of, you know, 'Are you a social worker?', 'Are you a mental health nurse?', 'Are you a psychologist?' Well, I do the same work and I've got enough experience and academic qualifications to say I'm quite capable of doing the work yet just not recognised.

I've done a lot of work in rural remote areas of Tasmania on the east coast and north coast of Tasmania. I've worked closely with GPs and now that I've left a psych practice I was employed as a counsellor under and gone into private practice the GPs are happy to continue working with me if I've got a provider number and I can't get that. You know, I've rung the Medicare line and said, you know, 'What does it take?' and pretty much, nah. I even have an AHPRA registration number because I'm also a qualified paramedic but I just can't get that recognition so it's a shame that the GPs won't refer to counsellors. You know, we really need to push that a little bit more and I've done some work just talking to GP groups at their practice to try and get them to understand our profession a little bit more so that - in their heads I think they just think their only option is to refer to a social worker or a psychologist - - -

PROF WHITEFORD: Sorry, can I just clarify that point. So do you think that is about the fact that their patient can go get a rebate or is that they didn't believe the counsellor could provide the treatment or the intervention that they believed their patient needed?

MS JONES: In my case because I've worked with the GPs they know I can provide the

service; it's the rebate. And particularly in the remote areas there's a lot of employment issues in remote areas of Tasmania and that's a lot of the presenting issues that they come to counselling for is housing, employment issues particularly those - like, I've had a 60 year old ex-tradesman come to me saying he's just at the end of his tether because he's been asked to go by on Newstart, is his only source of income, he's been asked to go and look for jobs and he's riddled with arthritis and he can't get these jobs so he's experiencing depression, anxiety and suicidal ideation.

PROF WHITEFORD: Sorry to keep interrupting. I know that you've probably got a script that you want to follow but I guess the challenge is between - you know, what you were saying there and what we've just heard from David about at one level the advantage of counselling is that it's not part of the mental health system, it's not connected to the mental health items on the medical benefit schedule, it's not medical, it's not clinical in the sense and so therefore it's less stigmatised perhaps and might be more accessible but on the other hand you need to get in there because there's no other - if I'm correct, no other source of financial support to do the counselling work; is that the right balance as I'm describing it or?

MR JONES: Yes, I think to me there is a link there in the fact that that's - because often - because of the poor job provision and everything else is that there's a sense there that these individuals don't have the capacity to pay quite often and their only source of being able to get access to services is through the Medicare Benefits Scheme so it's almost like they're happy with a mental health plan - - -

PROF WHITEFORD: But do you think that's the right thing? Like, would that be the right way to remunerate counsellors or should there be a different way of remunerating them so that they're not marked out as part of the MBS mental health - you know, - - -

MS JONES: We could apply for funding to support particular programs and Primary Health Tasmania do offer funding for short term psychological intervention which is a program that I had been working under at the psych practice that I was employed under but now I've gone into private practice, if I contact Primary Health and say, 'Can I also get that funding to continue to provide services?' one of the first questions I'm asked is, 'Are you a social worker? Are you a mental health nurse? Are you a psychologist?'

PROF WHITEFORD: So they would let you do that when you were part of the contract that they commissioned - like, the commissioned work, but that people outside of that contract aren't able to be supported to do that work?

MS JONES: In my experience. I don't know whether others have had better luck with it but in my experience, you know, because I worked with a psych practice and it was the psych practice that got the contract so now I've got a counselling practice I can't get one and there's so many people out in those remote areas that need services and there's like a four to six month waiting list to get in to see someone. We've got a pool of counsellors that could fill that gap but we're just not recognised.

PROF WHITEFORD: Okay, sorry for interrupting. Sorry, I'll let you finish off what you have started.

MS JONES: And we also see suicide rates increasing here in Tasmania particular amongst the male population. My other professional is a paramedic and I have seen people at the extreme end of their mental health where they've just got so frustrated with the system and not being able to get support and, you know, if you've got suicidal ideation you can't be waiting four months to get in to see someone so they really need to have a greater availability of resources and we've got it right here under our nose and I just don't understand why degree qualified people are not able to come onboard and offer these services and we're just not recognised. I mean, it's ridiculous. Mental health is just going through the roof. The health system is in crisis and we've got something right here, a resource that can help with that and just not recognised.

MS ABRAMSON: Do you have a view about the type of counsellors that will be providing the service because we know, for example, with psychologists that we got given some evidence this morning that they all have a basic training in particular things but may not specialise in it so when you think about the counselling group do you have a view of exactly which counsellors would be the ones that would be authorised to provide the service?

MS JONES: Well, I think under the Australian Counselling Association, level 3 and level 4 memberships would be appropriate because they are degree qualified. Not everyone needs to go to that level of membership and that's their choice but, you know, to be a level 3 - or I'm a level 4 member and that's - - -

MS ABRAMSON: What's involved in that?

MS JONES: I need to be degree qualified, have a minimum of six years post-qualification counselling experience including 1000 client contact hours and complete 100 hours of professional supervision so professional supervision (indistinct words) ethical and legal practice.

PROF WHITEFORD: Sorry, outcome measurement is something that's come up repeatedly with assessing the interventions provided by a range of psychological service providers; is there any collection of outcomes in the way that the counsellors practice in your experience?

MR JONES: Is that question directed towards are there any items like such as a K10 or - - -

PROF WHITEFORD: Yes, something like that.

MR JONES: Okay. Yes, it's actually a difficult - because you're not actually measuring an improvement in someone's mental health per se, what you're actually doing is perhaps observing a change in the quality of their life and their capacity to address day to day situations such as grief and loss, something that's - you know, somebody passes and you're not quite sure how you feel about that so you're really just talking to somebody (indistinct) you may be able to identify through something like grief therapy within three or four weeks and they seem to have come to terms with their part in that, how they feel about it, whether they want to move forward from that so there's unlikely to be a measurement or what you might see is a change in that person's urgency of demand for support in that space.

PROF WHITEFORD: So a different way of measuring it such as their reflection of their

quality of life or their wellbeing rather than the clinician (indistinct words) 'Do you have these symptoms?' sort of thing, is that what you're saying?

MR JONES: That's right, yes, yes.

MS JONES: And there is a quality of life measurement tool that we can use as well and the K10 is what we use in our practice and that's useful for the client as well because sometimes - like, we'll re-assess that after six sessions and they might get to that sixth session and thought, 'Oh, I haven't really improved' but you can actually show them you have and you can show them areas in which they've improved so it's quite a useful tool and it's good feedback to the GPs as well so we always (indistinct words) - - -

PROF WHITEFORD: Yes, so I guess that's another question we often ask because part of the concern we've heard expressed about the system is it's too many silos and not enough connectivity between the different provider groups and so your experience working with GPs or other providers?

MS JONES: Yes, I've worked closely with GPs but now I'm in private practice I'm not getting as many GP referrals because they are referring to the psychologists or people with provider numbers and that can be the social workers as well. Again, it's about keep on pushing that wheelbarrow to educate them and say, 'Not everyone needs to be on a mental health plan and not everyone needs to have the rebate' so some people can afford to be fee paying and it's just about making it an affordable rate. It's a bit like public versus private health insurance, you know, if we overload the public system with people that could afford to go private then it increases that burden so we need to educate the GPs as well to say, 'There is a percentage that needs a rebate so let's reserve that for those people and the others can be fee paying'.

MS ABRAMSON: If you've got any data on outcomes we'd be really interested in seeing that, that would be really helpful.

MS JONES: Yes, sure, yes.

MS ABRAMSON: But thank you very much, that was really helpful.

PROF WHITEFORD: Yes, thank you.

MS JONES: Thank you.

MS ABRAMSON: And the next person, can I welcome Mr Blair back to the Commission. If you'd be kind enough to state your name and your capacity in which you appear.

MR BLAIR: My name is Michael Blair and, yes, I'm here in a different capacity today representing the Australian College of Mental Health Nurses not as an individual where I was previously. The Australian College of Mental Health Nurses is the pre-eminent authority voice of the mental health nursing profession in Australia. It provides leadership and advocacy for mental health issues across the mental health sector in nursing and it sets national standards of practice in mental health nursing.

The College's initial submission to the Productivity Commission into mental health called for a more comprehensive insightful response to workforce issues in mental health. The College members and the board of directors acknowledge the work done by the Productivity Commission and calls on governments, both state and federal, to recognise the merits of the recommendations below and implement those recommendations. In particular we'd like to make comment on a couple of the recommendations. The first being a request for information under 7.1, freeing up psychiatrists for people who need them the most. Your question is what additional steps, if any, should be taken to support private psychiatrists to increase the number of consultations involving new patients? Our comment is that specialist mental health nurses have worked for many years alongside and in collaboration with psychiatrists and trainees in the private and public sector and this should be promoted as one way in which we can free up psychiatrists for people who need it the most.

The triage and counselling should not be seen as contrary or in competition to psychiatrists but work in synergy with psychiatrists in providing the care. The specialist mental health nurses also work in GP practice and have assisted GPs with persons with complex mental health issues and the accreditation practice standards for mental health that are developed by the College for nurses working with GPs has progressed and is available for evidence and this was completed as a project by some of my colleagues, (indistinct words) and I'll provide that reference. To enable this work to further occur, we will need to ensure that funding is targeted to the MBS line items for this work and compensation services is made available for the infrastructure and office needs et cetera.

In relation to draft recommendation 11.1 we would like to make comment on the mental health workforce issues divided between rural, regional and remote workforce. Targets need to be specific in addressing location as we roll out a whole of country workforce strategy. We cannot neglect our rural, remote regional areas of need.

We would also like to make reference to your recommendations in 11.3, which are more specialist mental health nurses. Initially the first recommendation would be that, as stated in your recommendations, accreditation standards should be developed for a three year direct entry degree in mental health nursing. We fully support that recommendation and believe that the recommendation should be implemented now rather than later. The two to five year recommendation timeframe was seen as being not adequate in the fact that we are really facing crisis at our present time.

Merits of introducing a specialist registration system for nurses with advanced qualifications in mental health; we also agree with that wholeheartedly and we'd also make recommendation that this should be enacted in the short-term, not the long-term.

We would also request that credential in mental health nurses be a stamp that is recognised by the profession to ensure ongoing professional development is maintained and clinical supervision provided to clinicians working in mental health as these standards are afforded to other allied health and medical colleagues, but not considered mandatory in nursing. It should be noted that many mental health nurse academics have also expressed enthusiasm online in work creating a curriculum that complies with the recommendation made for direct entry undergraduate entry. So that's promising.

We would ask that the mental health nurse incentive program be reintroduced and access to MBS line items made available to credentialled mental health nurses and this will ensure that other alternative options of treatment are available to consumers in the community as a component of their mental health plan.

And, finally, in relation to your information request under 19.2; personal care days for mental health, we would make comment that there is recently introduced 'mental wellness benefits' introduced by some of the larger companies in America and have allocated additional leave of 10 free wellness counselling sessions to all employees, and we believe that this would be of merit and that these would be in addition to what is currently offered as EAP.

And, finally, just in relation to Mr Asten's comments; I'm not sure he's still here but - - -

MS ABRAMSON: Yes, the mental (indistinct).

MR BLAIR: Previously I've mentioned the need for a national mental health act and I think that it was interesting that Mr Asten was calling for better coordination between state jurisdictions in relation to mental health orders. I think the national mental health act would be one option that would overcome that barrier and we acknowledge that there are a brand of understanding between the states and there's a lot of money put into ensuring that people don't fall through gaps. But certainly my experience and Mr Asten's experience is that that still does occur and that we need to address that.

MS ABRAMSON: Thank you (indistinct).

PROF WHITEFORD: Right, so just going back to the issue about undergraduate entry. So we understand that a curriculum was developed or has been developed.

MR BLAIR: Has; it needs to be updated.

PROF WHITEFORD: Sure.

MR BLAIR: I think it was taken offline - I don't quite remember, but I think it was late (indistinct).

MS ABRAMSON: You're on the transcript.

PROF WHITEFORD: That's why he said that.

MR BLAIR: Yes, and my memory's not so (indistinct), but it is still available and a lot of people have expressed interest recently since your recommendation that they would like to be involved in a collaborative effort to redevelop that curriculum.

PROF WHITEFORD: But from the perspective of the College of Mental Health Nurses which you're here representing today, that college is behind the recommendation.

MR BLAIR: Yes.

PROF WHITEFORD: And mental health nursing in regional and remote areas of Australia; a big challenge.

MR BLAIR: Yes.

PROF WHITEFORD: Any specific comments about how we can improve in that space?

MR BLAIR: Well, having worked and developed community health servicing in both Hopevale and Yarrabah in North Queensland, the issues that were discussed today about the stigma are very relevant when it comes to Indigenous mental health. The types of infrastructure and design of those health services was very aware of those issues and we put in place, you know - the discussion today about the west coast of Tasmania and how people would go from one town to another town in preference to being seen in their own town; it's the same in North Queensland, has the same issues. If you're seen walking into the health centre and you're going to see the psychiatrist who happens to be a fly-in, fly-out then, everybody in the community knows.

So we, through our architects, developed a method whereby the clinician would enter from a rear door, the client would be seen to enter from the front door. So I mean from a safety perspective it was good because there were two doors to the consulting room, but nobody could actually see who they were going to see and those rooms were used generically. So they were used as well, you know, by the dietician and the psychiatrist and the GP or whoever was visiting, and that got around that issue.

But then, there were issues about men's health and women's health; very separate and we had areas that were co-located but separate within the community health service. But mental health nurses; I hope that we'll be hearing from the Royal Flying Doctors Service this afternoon.

MS ABRAMSON: Yes, they're on this afternoon.

MR BLAIR: I have colleagues that work within the Flying Doctors service and provide that fly-in, fly-out service. Issues of clinical supervision for them are very relevant and very important and that's one of the things that, we say, is something that needs to be addressed is that, you know, you can't work as a sole practitioner without that supervision, without that reference point to, you know, get feedback on your practice.

MS ABRAMSON: Mr Blair, can I ask you about stigma within the profession - and we might've discussed this with you before.

MR BLAIR: Yes.

MS ABRAMSON: Sort of the activities that the college is undertaking to make it a more attractive proposition for people to take up mental health nursing, and you started to talk about that I think.

MR BLAIR: Yes, look, I've read the Health Community Services Union report to the Productivity Commission and/or it might've been to the Victorian Commission.

MS ABRAMSON: It might've been the Royal Commission, yes.

MR BLAIR: But they have a per capita report which is the first report that I've seen where there's been measures and a survey done of the number of mental health nurses with lived experience and be that as a carer, be that as having cared for a friend or be that as an individual with a mental illness, themselves, and it was interesting that this is the first time that that has ever been done within a health profession.

I think we talk a lot about lived experience, but there is lived experience within our professions and if we were to do more about identifying and bringing that out of the closet, I think we would address a lot of the stigma within the profession and that's probably the first time that I've seen it actually researched and identified and it's a whole new opportunity that needs to be unwrapped.

MS ABRAMSON: Well, thank you for drawing that to our attention, today. Thank you very much.

PROF WHITEFORD: Thank you.

MS ABRAMSON: Could I, please, ask our next participant, Connie - I may pronounce this wrong - Digolis from the Mental Health Council of Tasmania. If you would be kind enough to announce your name for the transcript and where you're from, thank you.

MS DIGOLIS: It's Connie Digolis.

MS ABRAMSON: Digolis.

MS DIGOLIS: From the Mental Health Council of Tasmania. I'm the CEO there.

MS ABRAMSON: And I'm assuming you have an opening statement that you'd like to make.

MS DIGOLIS: So, firstly, we'd like to acknowledge and thank the commissioners for their consideration of our formal submission to the inquiry in May this year, and acknowledge the breadth of the draft report and appreciate the multiple opportunities that you're actually offering ourselves and others to provide input and feedback into the final report.

Our role as the peak body for community managed mental health services is to provide an independent systemic view while also ensuring that we're advocating for better mental health outcomes for all Tasmanians. In regards to the draft report, and while we're preparing our submission to lodge in January, we've looked at, and are happy to provide some additional feedback, around the structural reforms and governance.

We welcome the considerations on addressing continuity of care within structural reforms and the need for intergovernmental agreement and the challenges that we currently have and that need to be addressed in regards to roles and responsibilities across all tiers of government. But we do wonder how we can ensure that that can be implemented successfully that was always in the detail.

We also have looked closely at the mental health and wellbeing in the schools area of the report and, while we applaud the recognition of the importance of perinatal and infant mental health and wellbeing, we'd also like to point out that we feel that there still may be some gaps. There's some great acknowledgement there around a whole of life and a lifespan approach, but we think there's more that we could be looking at in the primary school and especially in the high school areas as well, and actually looking at, for our high schools, looking towards less of a clinical-based and more of a strength-based approach and building skills and resilience within high school students themselves and looking at peer support models which are proving to be very successful.

We also have noted the national mental health workforce strategy and, while we acknowledge it's important to ensure that all existing and planned state and regional mental health workforce strategies are there. We've also got the regional planning that's actually happening, so we're wondering about the relationship between a national workforce strategy and the state and regional strategies and plans that we know are either in train or actually already exist. So we'd like to see more detail in how those various levels all actually talk to each other so we're not undoing the work or some of the directions that have already been set.

MS ABRAMSON: Thank you. The second bit, I might ask my colleague to speak to that around the workforce strategy and regional planning because we're very open to ideas which is part of the reason our models that we put out were for discussion, particularly around the RCAs. But are you happy to give some questions about the workforce (indistinct).

PROF WHITEFORD: Yes, so obviously it's a distributional issue and the development has been about national workforce model and that assumed then, that you've got a sufficient number of people estimated for Australia then, distribution of those across urban, regional, rural areas, even within states that have enough people is the challenge.

So there are methods that have, I guess, been applied to try and even out that distribution. Are you aware of anything that's specifically worked in Tasmania where they've tried to get services outside of major urban centres?

MS DIGOLIS: No, and certainly we've had discussion around incentivising and being able to setup partnerships with universities to be able to look at internships and incentivise graduating students to actually do some time in the rural and remote areas. But we've actually got shortages across the entire state, so in our urban areas, we've still got limited access towards psychologists and psychiatrists. We have a recognised, you know, clinical shortage across the board.

I guess one of the things that we often discuss and certainly the National Mental Health Service Planning Framework tool is showing us where those gaps are in our workforce. But what it's not necessarily meeting for us is where we can actually try and address it more creatively. So are there roles and new layers that we can bring within our clinical services and qualifications and those streams to actually be able to look at upskilling some and then, creating some new roles so that we can fill the workforce needs that way.

The previous presentation around the counsellors was a good example of how do we actually look at expanding their capacity to be able to fill some of those gaps and certainly, you know,

we could be looking at nursing streams as well, where we could be upskilling certain areas so that they're going into those streams.

PROF WHITEFORD: So has Tasmania applied the National Mental Health Service Planning Framework that you mentioned? And it has showed you, which you've just said, is the gap; does it show you how to close the gap?

MS DIGOLIS: No, it doesn't.

PROF WHITEFORD: No.

MS DIGOLIS: No, it shows the size of the problem rather than the solution.

PROF WHITEFORD: I think the size of the problem can sometimes be, I guess, advantageous if applications are made for, you know, governments (indistinct) or other funding to help close the gap because it's not - perhaps, the fact that you're saying we need more - there's a benchmark which has now been accepted and used in many places to try and (indistinct) the size of the gap.

In the area of the service planning framework, has there been much application on the low intensity side of things where we could use, perhaps, counsellors or other people in that earlier part of that stepped care approach?

MS DIGOLIS: I believe that we've actually got the information now so we can start looking at that. We haven't got down to the point where we're actually saying, 'This is the solution to be able to do that.'

PROF WHITEFORD: Okay.

MS DIGOLIS: But certainly the information should be there across the full continuum of care for us to be able to understand how we may be able to go into those lower level services and ensure that there's a suitable workforce there as well.

PROF WHITEFORD: Because I think - and the last comment from me - some of that is about, I guess we might call that elicit of efficiency, if we've got you know, psychologists working in the area where we can use them in an area where there's more complex need for example, we might be able to get a better distribution of those (indistinct) that is available and then, we know, perhaps, the most efficient way to get that coverage across that stepped care continuum.

MS DIGOLIS: And I think it's fair to say that we also haven't explored ehealth to the extent that we could as well. We can see that it is actually being employed in certain areas around the state, but I think it would be fair and reasonable to say that we haven't really looked at the effectiveness of it and how we might actually be able to get some greater reach by employing those types of methods as well.

PROF WHITEFORD: So, just again seeing as you've raised that, we have heard from Western Australia that they have expanded the MindSpot model of ehealth, which is run from

Macquarie University in Sydney through a program called PORTS and they've used that to cover parts of Western Australia, which would be more remote than most parts of Tasmania, and with some success and well taken up by the providers in those regional and remoter areas.

So I think you're right; I think we could do better in deploying that and a lot of the psychologists behind that program, as we understand it, are actually based in Sydney but they provide these services in Western Australia. So I think being more creative than we have been in the past, may be part of the - - -

MS DIGOLIS: Absolutely. And it's also the networking that we could look at within the health profession as well. So whether we could look at psychiatrists and psychologists being able to provide additional support to GPs than to people who are actually - health professionals who are actually based within our rural areas and provide an upskilling program in that was as well. That's another thing that hasn't actually been explored and could certainly provide some good opportunities.

PROF WHITEFORD: So I think - sorry, Julie; the last thing. We hear at these hearings a lot of - and we've covered a lot of them now - a lot of issues around these other problems, and the problems in Tasmania are challenging, but those problems duplicated across most of Australia unfortunately. What we are really keen to hear is what's worked. What's made a difference? If there's any examples of a solution that could be applicable across other parts of Australia, they're the ones that we can kind of capture and harness and get them into our report.

MS DIGOLIS: Great.

MS ABRAMSON: I have a couple of questions if I may, one is around psychosocial supports. When our report came out it gave an impression, which was not how we saw the world, that we thought that psychosocial supports were not as important as the clinical care. That was not the view of the Commission. But we need a little bit of help with a couple of things.

First of all, if your clinical need is quite low but your psychosocial support need is very high, we've been thinking around what might be the criteria for which you could then access the services. So we're happy to take that on notice. We've been asking a number of the participants if your trigger to getting your psychosocial support is not your clinical care if someone in your clinical care says, 'Actually, I need to refer you to a community-based mental health organisation.' It's how would people access those supports and on what basis might they access them. You can take it on notice.

MS DIGOLIS: Happy to partly to take it on notice because I think that's something that we could explore in our submission for January.

MS ABRAMSON: Yes.

MS DIGOLIS: But just in terms of a general response now, I think we've got - and you would've heard this - we've got to look at being able to simplify access for people and there's a lot to be said for peer support and for a peer workforce and we've been exploring how we can actually ensure that there are people with lived experience who are available in more points of the system, for individuals and families, to be able to discuss what their immediate, what they

believe their longer term needs might be and how someone with lived experience may actually be able to really enhance that pathway and be able to help them navigate those services. I think one of the challenging things around psychosocial supports around mental health challenges generally, is its always that point in time.

MS ABRAMSON: Yes.

MS DIGOLIS: So what that person needs on one day may be completely different the next day or the next week or the next month, and it's how we can be adept and flexible in being able to meet those regulating needs as they are at the moment in time, and whether that means that there's a contact service or a contact person - I'm reluctant to say care coordinator - but someone who's able to be able to provide that generalised support in helping them navigate what those services might be and the full breadth of those services then, perhaps, that's going to be able to improve people actually accessing the supports that are going to help them to function independently and at their best and healthiest.

MS ABRAMSON: Actually, it's interesting because I had not personally appreciated the distinction between peer support and peer workforce. So I'm really interested in having a bit more of a conversation about what you see as peer support and, as you would've seen in the report, we have a view about peer workforce and what not, but what does peer support look like?

MS DIGOLIS: To us, it looks like someone who can actually relate to any area of someone's aspect of life, and we've been exploring it ourselves because we're looking at some student models.

MS ABRAMSON: Yes.

MS DIGOLIS: And when we look at a student cohort then, their peers are their fellow students, and when they're talking about peer support, they're really just talking about somebody who may be a similar age group to them.

MS ABRAMSON: Yes.

MS DIGOLIS: When we're talking about someone who maybe having some mental health challenges and would actually like to be able to have some peer support, as they would see it, then, we're talking about someone who would have lived experience and who would be able to say to them, 'I'm not going to tell you how you need to do this or what your recovery needs to look like, but I can certainly loan my own experience to that,' and provide an example of what recovery can look like, and we're certainly learning the benefits and the benefits for the peer supporter but also, the person who's actually seeking that support in having someone being able to literally, you know, move shoulder-to-shoulder with them and say, 'I'm not going to tell you how to do it, but I've been there too and I can help.'

MS ABRAMSON: Thank you, the other issue is - we've made this request of a number of organisations in your position - is one of the things the Commission struggled with was seeing the workforce and the type of things that the community mental health sector does very clearly. When we looked at clinical support we could see gaps. But when we looked at the psychosocial

support we couldn't even see a system. In some cases, there was just a whole range of different services. So we're really interested in some more information about the type of services that are provided and sketching out some of the things that your members are actively doing with clients.

MS DIGOLIS: So, again, we can provide some more detail about particular programs in our submissions, but you can be looking at some high-intensive supports.

MS ABRAMSON: Yes.

MS DIGOLIS: So we would have packages of care that organisations are providing that would be providing usually time limited supports to individuals and families and they may have a clinical supervisor within that team, but largely, they might be looking at what we might refer to as more of an interdisciplinary team.

MS ABRAMSON: Yes.

MS DIGOLIS: So it's looking at the full range of needs for that person, whether it be housing, employment, education, training and actually focusing on their recovery. So you will find that a lot of organisations also use recovery tools.

MS ABRAMSON: Yes.

MS DIGOLIS: So the Star Recovery tool is a good example of that. It's very much around basing things on goal setting, on individual choice and on that individual being able to pace their recovery in a way that best suits them and, perhaps, that's why it can be challenging to understand and to be able to map the psychosocial supports because they do need to be so individualised and it can be difficult to be able to say, 'Here's a system,' when we're actually trying to deliver something and, in fact, I'd probably argue that the community managed mental health sector is, perhaps, the most effective deliverer of person centred care and that can consumer choice approach.

MS ABRAMSON: Yes.

MS DIGOLIS: And that means that it's very flexible and it can be a little bit more difficult to put your finger on exactly what's being delivered and you won't see consistency necessarily across services, but even within one service, because it needs to be able to be agile and to tailor for the needs of the individual.

MS ABRAMSON: But we've also heard in evidence elsewhere that it's been very difficult to get the workforce for - I mean you were talking before about planning - to get the workforce in some of these community-based programs. So I'm sure, if it's a problem in mainland Australia, I'm making an assumption it's also a problem in Tasmania.

MS DIGOLIS: It is a challenge here and certainly we have a shortage of allied health workers as well, but we can't ignore the funding issue.

MS ABRAMSON: Yes.

MS DIGOLIS: So it can be very difficult for community-managed services to be able to maintain and retain a workforce when they're constantly on two, one, three, five-year contracts.

PROF WHITEFORD: Yes.

MS ABRAMSON: Well, notice we had something to say about that.

MS DIGOLIS: Yes, exactly, so that becomes really challenging. That also brings - while we're touching on workforce again - that also brings that additional challenge about maintaining the professionalism of that workforce. So we have organisations that talk about actually having to put a hold on professional development for some of their staff because those staff are on short-term contracts. So they're not able to justify making an investment in further professional development for a workforce that may not be keeping because they may not have ongoing funding for that particular program or support.

MS ABRAMSON: Could I also ask you; how can we incorporate carers and family better in the type of supports that we provide? We've heard a range of things from the clinical side where it was quite acute where family carers said, 'I didn't know. I wasn't allowed to have information about my loved one,' which as you know, is a complex thing, but in the provision of these type of supports, how could we involve carers or family more, if we don't already?

MS DIGOLIS: And I know that you've got some care organisations who'll be able to provide more on that this afternoon.

MS ABRAMSON: Yes.

MS DIGOLIS: I think it's about, again, being able to encourage services and, perhaps, provide additional supports to services and organisations to really look at how they can upskill their staff, but also their programs in becoming more inclusive of families and friends as well.

It's interesting, on our drive up here we were actually talking about the challenge for mental health carers, in particular, and how that's different from other carers and, you know, acknowledging that it's often the fluctuating health of the individual which means that the needs for the carer and family member often change as well. But it's also, the risk that we actually overlook the needs of the carer, in particular, and I think while we are going for a person centred, individualised, tailored approach for recovery, I'm not sure how we actually incorporate the wellbeing of the family who are supporting, but I think there's certainly, rather than just looking at a narrow approach of how do we know that and ensure that the carer or family member is happy with the package of care that we have for their family member, how do we also ensure or take some responsibility for how that family member is actually managing things themselves and how their own physical and mental health and wellbeing is as well.

MS ABRAMSON: No, thank you, and we will ask some of the care organisations because one of the things that's been put to us is the need for carer support peer workers or peer support.

MS DIGOLIS: We've seen some fantastic models for that and we've certainly done some work in this state where we have some paid carer - - -

MS ABRAMSON: We'll be interested in that.

MS DIGOLIS: And I'm sure you'll have some organisations commenting on that this afternoon; but we certainly do have some recognised carer peer workers within our public mental health services. We've looked at some models internationally which are really interesting. We've talked about how families could be provided with additional support by carer services for example if they've had to have a family member, who's actually been removed from the home to be admitted, and how traumatic that can be for a family and how important it is for supports to be wrapped around that family, as well as the actual person who's unwell. So there are many things that we could explore that we would see would be a great benefit to families and carers.

MS ABRAMSON: We would welcome that in a submission. Just coincidentally, we have a team member here who's been working on the carers, so I should think she'll catch you later, so Harvey, did you - - -

PROF WHITEFORD: Fine, thank you.

MS ABRAMSON: Thank you so much. Could I have our next person, please, Ms Brett from the Psychotherapy and Counselling Federation of Australia? If you'd be kind enough to announce your name, where you're from, and I'm sure you've got an opening statement for us, thank you.

MS BRETT: Thank you. I'm the Chief Executive Office of PACFA, which is the Psychotherapy and Counselling Federation of Australia. So as the CEO of PACFA which is the leading peak body for counselling and psychotherapy in Australia, I have a unique perspective on the contribution that counsellors and psychotherapists can make to the mental health and wellbeing of the Australian community and in speaking to the Commission today, I'm going to be focusing on reform area 2 in the draft report; Closing critical gaps in health care services. However, I hope that much of what I have to say here today, is also broadly relevant to the Commission and to the ultimate goal of creating long-term reform that's sustainable and client centred.

It goes without saying that the mental health care system is in desperate need of reform to allow timely access to mental health support services by those needing this support. Clients should be able to access the right services from the most appropriate practitioners at the right time. This requires consideration of the whole mental health workforce, including counsellors and psychotherapists. This will ensure appropriate targeting of practitioners to client needs.

Now, your draft report found that there were gaps, not only in the funding and delivery of vital services, but also, in awareness of what constitutes mental ill health and the types of assistance available and the broad range of service providers who can provide that assistance. Counsellors and psychotherapists are a highly skilled, trusted, yet, underutilised part of the Australian mental health workforce. This inquiry presents an unprecedented opportunity to unlock the potential of this workforce and to break down barriers to access to counselling and psychotherapy for many Australians.

As I'm here to speak on behalf of PACFA and our members, it's crucial to understand the unique relation or therapeutic approach of counselling and psychotherapy as professions. The Commission has already heard, through submissions and evidence given in these hearings, about the importance of the therapeutic relationship between therapist and client.

Counsellors and psychotherapists are client-centred; that is what our training is. We are, by definition, relational practitioners. The therapeutic relationship between the practitioner and the client is central to our practice and it underpins the effectiveness of our treatments. Counsellors and psychotherapists are fully present with clients using empathy and deep listening to establish a positive working relationship with our clients. Counselling is effective when clients feel safe, understood, respected and accepted without judgment.

We work within clearly contracted and ethical relationships to support people to explore and resolve life difficulties. We work by respecting our clients, including their values, beliefs and individuality and their right to self-determination. So what this means is that professional counsellors use our therapeutic relationship as the centre of the way we work, but we're also using evidence-informed, intervention and strategies in the way that we work with our clients.

Now, you've asked at previous hearings what safeguards can be put in place to ensure the safe regulation of counsellors and psychotherapists, if we were to be included to provide MBS-funded services. I need to emphasise that these safeguards are already in place, and I will say more about this today.

Counsellors and psychotherapists that are registered with PACFA have completed an undergraduate or post-graduate training. They are trained in a range of modalities to work with children and young people, adults, couples, families and groups. They must meet clearly defined registration criteria, including clinical supervision requirements and ongoing professional development and they must work to a code of ethics.

So it's also important to understand that counselling and psychotherapy are interdisciplinary activities. So counselling and psychotherapy are provided by many different health professions, including counsellors and psychotherapists, as well as psychologists, social workers, occupational therapists and nurses, sometimes psychiatrists, and doctors.

Some of these health professions when they provide counselling and psychotherapy, they're doing that from a basis of a medical model. Whereas when the psychotherapy or counselling is provided by a counsellor or a psychotherapist with our specific type of training, it's a nonmedical biopsychosocial model.

MS ABRAMSON: I don't like to interrupt, but it's just I don't quite - it's not my training.

MS BRETT: Yes.

MS ABRAMSON: What does a psychotherapist actually do that's different from a counsellor? Because you've used the conversation a bit there, so I just wanted to understand.

MS BRETT: That's okay, I'll address that.

MS ABRAMSON: Yes.

MS BRETT: And, in fact, we have a one-pager which I can send to you, because I get asked this question all the time: 'What's the difference?' There's another peak body in Australia called the Australian Counselling Association. They essentially focus on counselling as a profession, whereas PACFA is psychotherapy and counselling, and the way we look at it is, they are different, but there's also a significant overlap.

So sometimes psychotherapists will talk about doing longer term work, more in-depth work, but I know counsellors that do long-term work and they go very deep. Sometimes counsellors might talk about being more solution-focused and short-term, but I know psychotherapists that sometimes do brief psychotherapy. So it's not black and white; there is an overlap. But probably from a professional identity perspective, psychotherapists would see themselves as having a different type of training formation.

They often talk about a tri-partied training model where the psychotherapy training involves three elements; the theoretical training, the supervisor practices - so we actually, within our training, do real work with real clients as part of our training. But the psychotherapists will have a third arm to their training, and that's personal experience of sitting in the client's chair and undergoing psychotherapy themselves. So it is a kind of lived experience in a way. We know exactly what it's like to do that work on ourselves.

MS ABRAMSON: Is that true of all psychotherapists or the ones that were in your association at Fairpoint?

MS BRETT: I would say it would be true of anyone who identifies professionally as a psychotherapist.

MS ABRAMSON: Yes.

MS BRETT: So some of them might not have been through a specific psychotherapy training in one modality. They might have done many different trainings, but the formation process of their life's work as a psychotherapist, has involved going very deeply into their own work. So, and counsellors do this as well. I trained as a counsellor, and certainly sat in the client's chair, as well as the therapist chair during my training, but this is perhaps emphasised more in psychotherapy training, but they've done a lot of their personal work, so they know what it's like to go through that journey of developing self-awareness, and grappling with our struggles and pain and difficulties and working through them with the support of their therapist. So, I'll happily send you the one pages, but it's not an easy question.

MS ABRAMSON: Thank you. I interrupted you, but - - -

MS BRETT: That's fine. That's absolutely fine. So let me see where I was. Yes, I was talking about some other profession work from a medical model. So what I mean by that is seeing mental illness as a disorder, a mental disorder, whereas the biopsychosocial model from which we work sees it as being multi-faceted. So we're much more focused on actively promoting mental health and wellbeing so it's that positive support within the model, as well

as focusing on treatment and prevention of mental illness. So, that does happen in the process of the talking therapy.

But very often – well, depending on what the presenting issue is from the client, we might have much more of an emphasis on prevention, early intervention, and support for mental health and wellbeing. So, I think that focus on client wellbeing is a unique identifier, or distinguishing feature of counselling and psychotherapy, as provided by counsellors and psychotherapists.

MS ABRAMSON: And you think that's different from psychologists?

MS BRETT: Well, it's hard for me to speak about psychologists, because I'm not – I'm not trained as a psychologist. But that was certainly my experience of counselling and psychotherapy training that I did, that it's very much a focus on wellbeing. It's very much more of a – I suppose you could say it's a holistic model, so it looks, like, at all aspects of our being, and our lives, and our participation in the community.

And in this regard, it's interesting; what you were asking just before about psychosocial support, because I have been a family carer for a few family members with mental health issues, and one of my family members who has bipolar disorder, has never accessed a formal service for psychosocial support, and assures me she has no intention of ever accessing that type of service. She says, 'Well, I wouldn't want to go there. Those people have all got bipolar disorder,' which makes me laugh.

So, but she has been encouraged and supported, by us as family members, to join her local pottery group. So, she's not going to get her psychosocial support by accessing a mental health services, she's actually participating in a local art group in her local community, and that's very supportive to her, and I know that if she didn't do that every Wednesday night, she would be at home, isolated, and probably, I don't know, spending a lot of time on Facebook and drinking a lot more alcohol.

So this is fantastic, that she has this positive outlet, and it doesn't always have to be a formal service. And I think this is where the encouragement and support of a counsellor is a way to support people to engage in what the community has to offer. That if you feel socially isolated and lacking in confidence, to go along to your local pottery group, that if you're having the support of a counsellor, and planning your activities on a weekly basis, what are you going to be doing to get out of the house, and doing something positive that engages you in your local community? I think that's where a counsellor can provide fantastic encouragement and support.

Can I say a little bit more about the training of counsellors and psychotherapists. You probably understand that there's a wide range of counselling from a diploma, or even no training at all, right through to undergraduate degrees, post graduate training and even a PhD, in counselling and psychotherapy.

MS ABRAMSON: We had evidence this morning.

MS BRETT: That's right.

MS ABRAMSON: Yes.

MS BRETT: So, counsellors and psychotherapists have what we would consider appropriate training, and who were endorsed by one of the peak bodies, they provide appropriate, cost-effective, treatment, and it's an option that we believe should be more easily available and accessible for patients with mild to moderate mental health issues. But this is where this, sort of, overlap between counselling and psychotherapy plays out, because it's not just that we see ourselves at the very bottom end of stepped care. Because if you've done psychotherapy training for six years, you're actually very skilled to work with people with quite complex issues, like personality disorders.

So it's not that – it's not as simple as saying, well, 'You stick counsellors down there, and you stick clinical psychologists up there in the stepped care model.' I think it depends on the practitioner, and it really depends on what their training is, and how experienced they are. So, I just wanted to make that point, because that picks up on some earlier discussions (indistinct).

PROF WHITEFORD: Sorry, can we just - - -

MS BRETT: Yes?

PROF WHITEFORD: Can we just grab it there. So, I guess the challenge that we've heard is that it does depend on the practitioner, and that not all counsellors or members of PACFA are the same. And even though there's standards, and there's supervision, and you've tried to create that consistency, that there is a continuum of skills and experience across the membership, which would be the same with, you know, a lot of other organisations as well. So, how can we match, as you said at the outset, the skills of the practitioner and the needs of the client in a stepped care approach, or whatever approach. In a big population health level, that's the challenge we've got - - -

MS BRETT: Look, I don't know if you know about this, but Adelaide PHN is doing some really interesting work. They are developing, and I think they're already implementing, a centralised referral system. So, the GPs, and I think a large number of GPs are participating in this centralised referral system. So rather than just doing their own selection of a psychologist, they'll come into the Adelaide PHN central referral system, and an assessment is done to actually match client needs with practitioner needs.

So, someone came in, who needed more intensive work, and if we get the reforms to better access that we're hoping for, and people will be able to access more than ten sessions, because some people sorely need more, it may be that they then get matched with a psychotherapist who is skilled to work with their kind of issues.

MS ABRAMSON: Except that, the psychotherapists – I might have got this wrong, but the psychotherapist doesn't have the access to better access. So the better access section's only for the psychologist.

MS BRETT: That is how it is at the moment. But what's really interesting about what they're doing with Adelaide PHN is, yes they've got the pool, right now, of the Medicare providers for better access, but they're actually including counsellors and psychotherapists in their referral

pool, because we heard somebody else speak this morning about how there are patients who have the capacity to pay for private counselling. But the default referral pathway is, 'Well, here's a referral with your mental health plan to go and see a psychologist', and actually, that particular patient might be better served by going privately. They have the capacity to pay.

We are starting to see some rebates for private health insurance being available, for counsellors and psychotherapists. We need a lot more, and we're working on that, but we have BUPA now, and that's the most positive and accessible private health rebates. Some of the other health funds, it's a bit of a limited offering of rebates, whereas BUPA has really come to the party - - -

PROF WHITEFORD: Sorry. So on that: there is, we're well aware of this initial assessment and referral that the PHNs have been asked to do, this IAR approach that they've all been asked to take on to try and match the individual needs to the appropriate intensity of service. And what you've just said is that for some of the commissioning dollars, that the PHNs have, they're looking at the providers in the geographic area, and trying to match the individual clients/patients coming into the system with that, and remunerating that service by commission dollars, rather than Medicare benefit schedule?

MS BRETT: Yes.

MS ABRAMSON: Yes, okay.

MS BRETT: We're interested in that model, and you're jumping ahead in my presentation.

PROF WHITEFORD: Sorry.

MS BRETT: What I wanted to say is, we're working right now, without partner of the Australian Counselling Association, we're working on advocating for counsellors and psychotherapists with appropriate qualification, to be added to the better access initiative. And your question earlier today was interesting, you know, is that the best way, or could counsellors perhaps sit outside the system? I don't see it as an either/or.

I absolutely think counsellors and psychotherapists need to be added to that system because we have significant workforce shortages, and also there are issues of client choice. So, let me say something about client choice, because this is where the research evidence really helps us, because people are more – the research finds that people are more likely to seek help if they can consult the practitioner that they actually feel comfortable with, and want to work with.

And sometimes, what happens is you might access some counselling through an employee assistance program. Maybe you develop a great relationship with that counsellor, but you've only got six sessions through your EAP. You want to carry on with counselling, so you go to GP – you go to the GP to get the referral, but your counsellor actually hasn't got a Medicare number. So you actually have to stop with that counsellor and start again with someone who's got a Medicare number, possibly a psychologist. So we've got an interruption to the continuity of care. So, if the client had the opportunity to continue with the counsellor they're working with, the evidence – the research evidence says that will actually support better outcomes.

So, the other issue is, some people have an experience with a particular practitioner, and it doesn't always go well, and they might shop around. Or they might terminate treatment after only one or two sessions, because they don't feel a connection. So I think the research evidence tells us that they may get a better outcome if they can actually choose the practitioner that they feel comfortable with.

MS ABRAMSON: But how do we – and I know we're interrupting you, but how do you get the positions of the consumer to make an informed choice? Out there in consumer land, there are all of these services, taking a provider that a consumer is prepared and able to pay, how would they know which service to access? What would your organisation say about helping them access services?

MS BRETT: Look, I think there's more work to be done here. We're doing a piece of work right now to enable people to search on average as to specialisation. So, some people have done their bibliotherapy, and they know what they're looking for, because they've been reading up about it. Others haven't really got any idea what might help them. But they might be able to search by specialisation; they might want a psychotherapist, rather than a counsellor; they might want a relationship counsellor. So we have a college of relationship counsellors. So if their core issue is around relationship difficulties, they might want to seek out someone who has that specialisation.

Now, I think is one of the real failings of better access. It's very generic, and it's very narrow, the type of interventions that people can access. And I actually think it's also really important – like, it's almost a bit like government doesn't trust a highly skilled practitioner to choose the most appropriate intervention.

MS ABRAMSON: The government worries about the funding for these things.

MS BRETT: I'm sure. But the government says, 'You're only allowed to do focused psychological strategies', which is essentially CBT and a few other miscellaneous types of treatments. So instead of trusting the practitioner to choose the most appropriate intervention, that's imposed. Now, I trained in (indistinct) counselling, so I don't just use one thing. I can actually integrate a range of different treatments, in response to what the needs of the clients are. So, you're right, the client might not know what they need. But you actually have a professional therapist, who actually can do an assessment to determine what is actually going to be most appropriate and effective.

MS ABRAMSON: You have to have that triage process, though, and what you said about the Adelaide PHN, really is part of the model there, that somebody is making an assessment.

MS BRETT: Yes, yes. I'll just tell you a little bit about the research evidence. There's research into the common factors underlying the effectiveness of counselling and psychotherapy, and I can send you more - - -

MS ABRAMSON: We would actually be pleased to see the research, and the evidence.

MS BRETT: Yes, yes. So I'll send you this, it's got research evidence, but I've got some additional research references that I can send you. The common factors research talks about

how all types of therapies, broadly speaking, achieve broadly similar outcomes. So actually, it could be a psychologist doing CBT, or it could be a psychotherapist doing gestalt set therapy. The common factors research finds that all of these types of therapy achieve broadly similar outcomes, and it's the strength of the client therapist relationship that's the key determinant of the outcomes.

MS ABRAMSON: How does – this is just the lawyer in me, so I'm apologising in advance, but how does that make your case that they – that the government should fund psychotherapists and counsellors, if psychologists are already getting those outcomes, what's your argument as why your organisation, if it's the same outcomes? I'm not – this is just for the purposes of us having a conversation, it's not (indistinct) - - -

MS BRETT: No, I understand. Well, there's certainly research evidence that says CBT is effective, but it's not effective for everyone.

MS ABRAMSON: But you're saying it's who delivers the CBT that's - - -

MS BRETT: That's right. So you could have a really good psychologist delivering it, or you could have a really good counsellor delivering it. But you might have a psychologist or a counsellor that doesn't develop a good therapeutic relationship, and it might not be effective. So it's actually not about the practitioner, it's about the relationship the capacity of that practitioner to develop that relationship. And this is where we come back to counselling and psychotherapy training, because our training is relational. So we actually are, I believe, really good at developing therapeutic relationships with our clients.

MS ABRAMSON: But I wouldn't thought the idea of therapeutic relationship would apply for any treating professional that you see? It doesn't matter whether it's a counsellor or your GP, or whatever, it seems to me it matters for all of those type of things.

MS BRETT: It does. But I think what I want to say about our training is that – let me come to that part of our – my presentation.

MS ABRAMSON: We are a little time pressed.

MS BRETT: Okay, all right.

MS ABRAMSON: And I know we've interrupted you, by the way.

MS BRETT: That's okay. I can't see the part in my presentation - - -

MS ABRAMSON: We certainly welcome a written submission.

MS BRETT: Look, I'll put this in. This would be in addition to the written submission about (indistinct) January. I can send you this, because I've actually - - -

MS ABRAMSON: Would you like that taken as a submission, as well?

MS BRETT: Not today, it's got my scribble all over it.

MS ABRAMSON: No, but you can email us, and we'll take it as a formal submission.

MS BRETT: Yes. Well look, all I wanted to say about the training is, this is by definition what counselling and psychotherapy training is. It's a relational training. We don't do a degree in psychology to learn about cognition and behaviour. We do a degree to learn how to sit with a room – sit in the room, with the client, and work with them, relationally. So, if the common factor's research says, this is the key factor, determining positive outcomes, what I'm saying is, we are trained in that.

MS ABRAMSON: All right, I understand.

MS BRETT: So I think that's a unique contribution we can make.

MS ABRAMSON: Yes.

PROF WHITEFORD: Time for one more quick question from me?

MS BRETT: Okay.

PROF WHITEFORD: How many members does PACFA have?

MS BRETT: We've got about two and a half thousand members in these categories, that we're recommending, not lower categories. We're in partnership with the ACA, and they, I think, have slightly higher numbers. So together we have the Australian Register of Counsellors and Psychotherapists, and I think there would be more than 5,000 registered practitioners, 25 per cent of whom are in rural and regional areas.

PROF WHITEFORD: And that's the group you believe would be eligible to – excuse me – provide the services you're talking about that could be rebate-able through better access?

MS BRETT: That's right. And if I could say one more thing, which I just want to highlight right now, and you'll read about it when I send this to you on the email: we recognise that the MBS is not the whole system. It's a big part of the current mental health support system. It's a bit inadequate for purpose, and it certainly needs developing and improving, and we believe that the addition of counsellors and psychotherapists would go a long way towards improving it. But that's not the whole of the system, and we actually welcome the emphasis in the Productivity Commission's report on other types of funding models.

So, we'll put something in writing, in January, about some of the issues about the quality and consistency of services, when they're being commissioned locally. But it is true, and we support the fact that there are many other ways to do the services, and there should be other funding models. So yes, by all means, let's improve better access, let's strengthen the workforce, let's expand the workforce, let's make more than just psychosocial strategies available through that, because there are many other effective treatments. But let's also look at other funding streams.

MS ABRAMSON: We're very interested in that, and we would encourage you very strongly, in your submission to talk to us about other funding mechanisms.

MS BRETT: I will, yes. And there are many places that counsellors already work, private practice, non-government organisations, where there are some excellent services.

MS ABRAMSON: The other thing in your submission is we're very interested in outcome data, so cost of service and their outcomes, so any information you have on that. And you've been very patient, because we have interrogated you, so I thank you very much.

MS BRETT: No, that's okay. I expected to not get through the presentation, but that's why I've got it ready to go in writing.

MS ABRAMSON: Thank you so much.

MS BRETT: Thank you.

PROF WHITEFORD: Thank you.

MS ABRAMSON: We will now take a break for lunch, and we will resume at 1.30. Thank you.

LUNCHEON ADJOURNMENT

[12.40 PM]

RESUMED

[1.29 pm]

MS ABRAMSON: Thank you. I'll reconvene the hearing. Just a few reminders from this morning for the new participants that are here. We like to conduct all our hearings in a reasonably informal manner but there are clear structures in our legislation to how these hearings are legally backed and full transcript is being taken. For this reason, comments from the floor cannot be taken. The transcript from today will be made available to participants. Additionally, I am happy to take other participants at the end of the day as we do have a little bit of time if there are people who have not put their appearance in and wish to be heard.

Participants are not required to take an oath, but they should be truthful in their remarks and you're welcome to comment on the issues raised in other submissions. You're free to enter and exit the room as you want. If you experience any distress, our staff are here to help you and our staff are over in the corner over there.

In the unlikely event of an emergency requiring evacuation, please follow the exit signs to the corner car park at Thistle and Glen Dhu Streets unless given an alternative assembly location by fire wardens. And given that we're visitors here, I should think we'll be following you out the building. So thank you. With that, could I please ask that Caring Fairly, Adele Beasley, if you'd like to take the stand and if you could say who you are, on whose behalf you're appearing

and if you have an opening statement, we'd be very happy to have it. Thank you. Are we good to go?

MS BEASLEY: Thank you. My name is Adele Beasley. I'm here representing Caring Fairly. And I am also the manager of policy and campaigns at Mind Australia. But today representing Caring Fairly. So thank you so much for the opportunity to speak to you about the important role that carers play in society. And congratulations to the Commissioners on a monumental draft report.

We think that there is much to be excited about in this report and we thank you for your commitment to addressing the needs of carers and families. I also wanted to take the opportunity to thank you for the collaborative nature in which you've conducted the inquiry. You've been out and about and speaking to a lot of different people and taking on board a lot of different comments so thank you for that.

So today as I said, I'm representing Caring Fairly which is a movement that wants to lead a new public conversation about the value of those who care. Caring Fairly is coordinated by Mind and is supported by a growing coalition of allies and grassroots supporters from across Australia. It's particularly focussed on policies that bridge the gap between unpaid care and workforce participation. So we have invested in leading and (indistinct) leading edge research and produced evidence based policies that provoke fair and more inclusive outcomes for all unpaid carers in Australia. At home, in the workplace and in society.

And while Caring Fairly represents all unpaid carers, we'll limit the focus today to mental health unpaid carers and we'll also concentrate specifically on mental health carers' participation in the workforce, allowing the other carer representative bodies to focus on care inclusive practices more generally – more specifically, I should say.

So we believe that this inquiry represents an opportunity to think about the care economy, so ensuring that valuable work does not bring about negative effects on employment earnings and financial security. We note and welcome the Commission's focus on person-centred care or consumer-centred care and think that this involves both – this can involve both the consumer and the carer because we know that that relationship is not linear and that carers can become consumers and consumers can become carers.

And so therefore, it's not a neatly defined role. And when you think about the person being affected by mental ill-health and we need to understand how that affects the families and the carers and their loved ones. So – which also extends into the workplace. And so when we're talking about mental health – mentally healthy workplaces, we also need to think about how carers play a part in having a mentally healthy workplace.

So we think the measures that are outlined by the Commission in the draft report will go a long way to addressing the needs of carers and families, but there's just some additional points that we wanted to focus on for today's discussion.

So we note and welcome the focus on the carer payment and carer allowance. And we welcome the recommendation into improving flexibility in regard to the 25 hour rule but want to sort of speak further about how – whether there is actual scope to abolish this rule entirely. And

because the draft report says that it – that the 25 hour rule, the check that carers are actually providing a significant amount of care, but as you state it's an imperfect control because the (indistinct) is about time spent on some activities but not all such as leisure time. And it does not take into account the episodic nature of some mental ill – mental health care needs.

And we know that carers are effectively on call to the person for whom they are caring for even when they're not actively providing care and we know that emotional support makes up the bulk of the care and responsibility as well. So we also note that the Commission says in the report that you're sensitive to the need to prevent people from claiming benefits to which they are not entitled. And suggest that the taper rates apply in terms of removing 50 cents to the dollar, goes a lot of way to ensuring that people are not claiming the benefits to which they're not entitled.

And the overall intention of, you know, precluding people from working, studying or volunteering for more than 25 hours per week seems to be at odds with Government policies which encourage people to attain further qualifications and progress financially.

In relation to the carers and work program, we welcome your recommendation to evaluate the carers and work program to inform guidelines that job active providers can use to tailor their services to the needs of current and formal mental health carers. Thank you.

I'd like to speak specifically about the flagship policy for the Caring Fairly campaign, which is to implement a national framework for care-inclusive workplaces. So we believe a coordinated Australian Government policy framework is needed to guide workplace reforms, create incentives and address the specific needs of carers in accessing equal employment opportunities.

PROF WHITEFORD: Sorry, just people sometimes in the back can't hear if the voice drops. So if you just – you know, it's hard in this room.

MS ABRAMSON: And the microphone's only for the transcript so it doesn't amplify.

MS BEASLEY: So unpaid carers need tailored employment support services and while workplaces need to adapt and change, in parallel leadership and coordination, must come from the Government. Caring Fairly advocates for a national framework for care inclusive workplaces. We believe this should involve relevant departments such as the Department of Social Services, investing in co-designing framework that can be implemented.

I'd also like to speak about women and care. So care and responsibilities can emerge for anyone but data shows that the effects of unpaid care on employment are experienced more acutely by women than men. We therefore suggest the Workforce Gender Equality Agency is involved in discussions about care inclusive workplaces. And we also note that the Commission has hasn't addressed superannuation in your report.

MS ABRAMSON: Not in this report.

MS BEASLEY: Not in this report. So whilst we understand that it may be beyond the scope of this report to fix superannuation more broadly, we do think it's worth consideration for

mental health carers specifically given that we know that women are more likely to be carers than men and women retire with a lot less superannuation than men. So the Commission may want to investigate providing a superannuation guarantee or an associated benefit to people who are on carer payments.

And in relation to young carers, my last point, we note the Commission's reference to young carers in the report and thank you for understanding that this cohort have unique needs. We understand that you're addressing this concern by recommending wellbeing leaders are placed in schools and as part of their responsibilities, they should support schools to better identify and support young carers.

We'd like to emphasize that there needs to be formal links with community mental health providers to be able to refer into them and to support young carers after they finish school. And Mind has actually undertaken some research in relation to young carers. We have a research project we're undertaking called Educational Engagement for Young People Who Care for Parents with Mental Ill-Health which aims to understand the young care experience in relation to education and the point of view of the young carer, their parent and their teacher.

MS ABRAMSON: When will that research project – what's its timeline?

MS BEASLEY: It's very much in its infancy unfortunately for this report.

MS ABRAMSON: Yes.

MS BEASLEY: So I will – I'm hoping to be able to work with our researchers and see what we can be able to provide for you in relation to this report.

And that's all for my opening statement, so thank you.

MS ABRAMSON: Thank you very much. I'm interested in learning a bit more about the mental health carers' participation in the workforce document that you talked about and what you're recommending? I have seen some of the notes here, but I really welcome having it for the transcript.

MS BEASLEY: So Caring Fairly advocates for a national framework.

MS ABRAMSON: Yes.

MS BEASLEY: So as part of this framework, there should be existing initiatives to address the mental health stigma in the workplace. They should be extended to recognise and include the impact on employees who are caring. Employers should directly provide information and commit to offering or providing linkages to support services for carers within the workforce. They should – employers should be encouraged to adopt a policy for examining job re-design possibilities such as flexible workplace arrangements, homeworking, leave arrangements and those sorts of things. And employers should be encouraged to undertake job redesign to accommodate carers with intensive caring commitments that extend, you know, beyond three months or require more than 20 hours of care provision per week.

Carers Australia has a working care initiative guide and so it could draw upon this guide to implement the framework. And in the UK, to look at an international example, there's the UK Carers Action Plan and this is an example of multi and cross-departmental agencies working together in order to improve carer's participation.

MS ABRAMSON: Thank you. We're particularly interested in small business and I'm just wondering, in the context of small business, how some of these things could be accommodated. So certainly for large businesses and if you've got multiple sites, you know, there – you've got much more flexibility, but one of the things that we've looked at in the report in particular is if you're in a small workplace, what can be done and we've been thinking who could support smaller employers and that might either be Government or industry (indistinct) so we're interested in your views on that.

MS BEASLEY: I might have to take that one on notice and take that back to our coalition and have a chat to them because I know from the discussions I've been having, we have talked about you know, doing a – the benefits of having a pilot or a test and that may – the tests would probably be better suited to a larger organisation who has the resources to be able to do this. But I'll take it back to my colleagues and have a think about it some more.

MS ABRAMSON: That would be great. Thank you. Also, what is it about mental health carers that's different from other carers in terms of the workplace? We had some ideas about that, but it would be good to hear it directly from you.

MS BEASLEY: I think it's about the episodic nature of mental health, because you can't guarantee when you're going to be needed and so therefore, there may be periods where you are, you know, when you need to be with the person who you're caring for at all times. And then there may be periods where that person is well and they are able to look after themselves. So it's the unpredictability of that relationship and of that caring responsibility.

MS ABRAMSON: Well, it's interesting because we certainly looked at that when we looked at the big programs that were being delivered, it didn't really deal, you know, social security, didn't really deal well with episodic nature and that's why with some of those work tests and things, we had a really good look. The biggest sort of stricture on us is that we were only looking through the lens of mental health, but of course, carer payments affect a broad range and we couldn't be sure if we made a change in one area, what the impact would be on the carer group overall. So were a bit more narrowly focussed. Harvey?

PROF WHITEFORD: No, I think the main thing is to, I guess, understand the difference for mental health carers, because a lot of the programs we saw when we looked at this were designed for carers of people with physical disability and didn't cope well. It was like as we've said in the draft report, it seemed like mental health was bolted onto a program that was originally designed with that in mind. The (indistinct) often didn't reflect some of the nuances, I suppose. So, how to deal with that would be useful. I guess the other thing was that many carers said that it wasn't about replacing the care they provided by a paid professional, because (1) they didn't want that replaced and the consumer didn't want that replaced either, so it's about the flexibility that the carer would need to continue to provide their caring role. Is that the thrust of what you're - - -

MS BEASLEY: Yes, that's exactly the policy of Caring Fairly. It's beyond (indistinct) Government to replace that care. I know that you've estimated the economic value of that and it's huge. But it's, yes, it's exactly as they're saying. It's about the flexibility to maintain that caring role, but also be able to balance the need between having a paid job and being able to take on that caring role, so we think about it in terms of a care economy.

PROF WHITEFORD: Yes.

MS BEASLEY: Basically. And how we can have those flexible working arrangements in order to enable people to do both and to get value from both.

MS ABRAMSON: I'm also interested – we had a bit of a discussion this morning, you may want to leave it for your colleagues that are following but carer peer support, it's not something I'll be honest that I had actually thought of. We thought about peer support for the consumer, so just interested in what that looks like from your perspective.

MS BEASLEY: I may leave that for my colleagues if that's okay.

MS ABRAMSON: Yes, of course.

MS BEASLEY: We have talked about that.

MS ABRAMSON: Who I hope are in the room at the moment.

MS BEASLEY: We have talked about that and Caring Fairly obviously speaks with other caring organisations. We've talked a lot about that. It is important to note the difference between consumer peer support and carer peer support because they are unique cohorts.

MS ABRAMSON: Yes.

MS BEASLEY: Acknowledging that there – it's not a neatly defined relationship as I said before. But they are unique cohorts of people. So there are some differences.

MS ABRAMSON: No, thank you for – the other thing you might be able to comment on. In our report, there was evidence that the economic and social outcomes for young carers of mentally ill people were substantially worse than – for young carers of other types of disabilities. In fact, I think we saw that – like, the team's in the room - but we saw their attachment to education was worse, which meant that their employment prospects were diminished. So we're very interested in that with a proviso of saying, well, what would the replacement care be so that young carers could concentrate more on education and things like that so we're interested in any news on that and happy for you to take that on notice. We just want to make clear that we know that's an issue but we're looking for some solutions.

MS BEASLEY: Okay.

MS ABRAMSON: Thank you. Harvey?

PROF WHITEFORD: That's fine.

MS ABRAMSON: No? Thank you very much.

MS BEASLEY: Thank you.

MS ABRAMSON: Thank you. If I could ask Maxine Griffiths from Mental Health Families and Friends Tasmania. If you'd be kind enough to take your seat, to announce your name, where you're from and I'm assuming you have an opening statement you'd like to make?

MS GRIFFITHS: Thank you very much. My name's Maxine Griffiths and I'm representing Mental Health Families and Friends Tasmania. Mental Health Families and Friends Tas is a peak body established to support and advocate for and with families, friends and carers of people living with mental ill-health. We have been and remain involved in Tasmania's recent reform announcements to integrate State Government managed mental health services to better meet need in Tasmania.

We articulate our jurisdiction's needs at a federal level through membership to our national body, Mental Health Carers Australia. We welcome this opportunity to have a say about the draft report authored by the Productivity Commission. Mental Health Families and Friends wants mental health reform to embed person-centred principles with individuals, their families and carers involved in all aspects of system design, implementation and review.

We want to see services that respond to the individual needs and preferences of people. Not people fitting into an inflexible and uncoordinated system, that on the face of it appears to be meeting the needs of service providers funded by Government rather than families, friends and carers and consumers in need. We want to see governments genuinely address and respond to the social determinates of mental health. Access to secure housing, appropriate levels of education and access to meaningful employment. We want to see a system that addresses the whole person, including their most important relationships with their families, their friends and broader community, and lifestyle needs and preferences.

We want to see services that are responsive to the needs of families as they travel the often irregular sign-posted journey to wellness and some form of reasonable functioning.

We see this inquiry as an essential component in mental health reform. This represents a key opportunity to see real change to the way mental health services are planned, funded and delivered, from early intervention and prevention to acute care, to allowing all Australians to eventually take responsibility for their own mental wellness.

We note that for many people, their families and carers are with them at every step of their journey through the mental health system. For those who have not had a close family or friend relationship, we hope that services and general community members will look beyond the actual delivery of service and see the whole person.

Families and supporters deserve better. Their voices need to be heard and they need to be afforded the dignity and recognition that has been lacking for so long.

In response to aspects of the draft report, it's noted that the report focuses on clinical aspects of

mental health services and not so much psychosocial aspects.

MS ABRAMSON: I'm happy to speak to you further about that.

MS GRIFFITHS: Thank you. Family and carer inclusion is not embedded in the overall document, indicating perhaps a lack of understanding of the relational model of care and support and the reality of the commitment and care that's provided by families, friends and unpaid carers.

The development of a national consumer and mental health family and carer co-production framework could be applied across all system and service settings, mandating the use of the Practical Guide for Working with Carers of People with a Mental Illness across all service provision.

In Tasmania, our chief psychiatrist has committed to support the rollout of this guide across all public community mental health services. How that will be funded, I'm not sure.

In the section where we talk about workforce, we don't see the mention of the large family carer workforce, larger than the paid workforce. What is to be done to sustain this undervalued and currently stretched workforce. Carer-inclusive practice must be mandated just as the recovery of model of care is for individuals. The Carer Experience Survey which has been rolled out across the country is not enough, as it's not binding or connected to funding outcomes.

We believe that the stepped care model needs to include families, friends and carers. Innovation is not mentioned, and there's no incentive for services to innovate.

A carer peer workforce needs to be included in commissioning bids from service providers and should be mandated by funders. We support a national approach to a carer peer workforce with appropriate training, professional support for workers and a career path across all jurisdictions.

What's missing in Australia is a family and carer non-legal advocacy program or service, and we need this to be supported and sustained.

We note in the report that it doesn't talk about comorbidity, so where a person may have a mental illness but may also have either an intellectual disability or a drug and alcohol addiction. Services in Australia tend to be siloed, which adversely impacts families, friends and carers.

The PC recommendations need a much greater emphasis and investment in a relational based approach to recovery, with a stronger vision that better integrates clinical and psychosocial as one system supporting the lifetime journey of consumers and their families who are impacted by mental ill health.

We would like to see more detail about how a specific national mental health carer peer workforce could be funded and deployed. We've heard that many families and carers have benefited from the wisdom and experience of those who have been before them on the recovery journey. We believe that a dedicated mental health carer peer workforce could provide social and economic benefits that are yet untested and strongly support the implementation and evaluation of a national mental health carer peer workforce.

We also believe that the report needs to talk about reducing barriers to accessing income support for mental health carers, and access to super whilst providing ongoing support has been brought to our attention. Thank you.

MS ABRAMSON: Thank you very much. I have quite a few questions, if that's okay. One of the things that we've said to a number of other participants and my colleague, Stephen King, did a major speech on this to Mental Health Australia. Our report looked like we were preferencing clinical services over psychosocial, which we weren't, and we know that they're interconnected, but we also know that there is a cohort of people for whom the psychosocial supports are the really important part and they may be clinically stable or not want to access clinical services, so we understood that we hadn't fully articulated that, and in our final report we've understood that point.

Which comes to my point. We need a bit of help from the sector. One of the reasons that the report looked the way it did was because whilst we could see gaps in clinical services - we could see exactly where they were - with psychosocial supports, a lot of the support was hidden for us, because it wasn't measured or we didn't see the workforce. So we've said to a number of stakeholders it's really helpful if you can outline to us - you're talking about carers. These are the type of supports that make a difference. These are the type of supports that are being accessed, and where you know what the funding support for those, so that would be a great help to us.

I'd like to know a little bit more about the national consumer and mental health family and carer co-production that you spoke about.

MS GRIFFITHS: We believe that one of the most important things that we hear from families is that they want to be involved in the development of a policy, of service design, because they have, from their lived experience, some valuable experience to offer. So we can go about this by saying that Tasmania could do it our way and Victoria could do it their way, but we think we have an opportunity here to have a national approach around co-production and co-design so that there are some basic principles developed around what it is, what it isn't, so that families themselves, once they understand what those principles are, they can actually start to ask to be involved and possibly demand to be involved.

In our experience in Tasmania, there seems to be a variety of interpretations of what co-design and co-production is, so I think to help all of us across the country to have a standard framework which would help all jurisdictions would be very helpful.

Now, what that actually looks like, I can't say right now, but to me it's about having some fundamental principles to guide service design and to guide organisations on how to include families and friends and also consumers in the design of services, so it's like a how to.

MS ABRAMSON: We have struggled a bit in the report between competing issues, which is the privacy around a consumer, especially, you know, that awkward age sort of with adolescents. When they're adults, it's even more difficult, but a number of carers have said to us, 'It's really hard because we couldn't find out what the problem was with our loved one, or what the care was,' so there was that part of the family, and then there were other consumers

who said, 'Well, I didn't actually want my family to know but I would have liked this support person to know.'

We've also been given evidence that when the question or the conversation is approached appropriately by the medical professionals, that most of the time people do give consent and it's the way in which they have the conversation with the consumer about the release of the information to the carer, so I'm just interested in your views on that.

MS GRIFFITHS: Yes, certainly from our experience when we talk to clinicians and when we talk to mental health staff, they sometimes say to us, 'Well, we don't know how to have the conversation. We don't know how to start it.' Or they may have had experience where they've had a 'no' several times, so they're reluctant to ask again, but on the whole the majority of clinicians and medical staff feel that they can ask the question and if there's a 'no' first, they will ask again and it's usually okay, but it's also okay to have a 'no'.

I think there's sometimes some confusion about what it is that families want to know and it often is not the content of the conversation between the consumer and the clinician. They really want to know is everything going to be okay. Is everything all right? Or, 'Because I'm the carer at home, is there something that I need to know to look out for?'. So I think we need to be clear about what it is families are asking and for clinicians and mental health staff to understand how to have the conversation, and that confidentiality often doesn't come into it because it's not the content of conversation that often families want. It's that - - -

MS ABRAMSON: No, that's very helpful. Harvey?

PROF WHITEFORD: So there was a few things you mentioned that didn't seem to be covered in the report. Comorbidity was one. So there's a whole chapter on comorbidity, so I'm just wondering what in that chapter we missed or wasn't in there?

MS GRIFFITHS: So around the siloing. I think if I can speak from a family's perspective.

PROF WHITEFORD: Sure.

MS GRIFFITHS: That is, providing support to a person who has a range of issues; one might be mental health, one might be drug and alcohol, in Tassie at least, we have very siloed services, and so that families may receive support in very different ways from the mental health sector from the drug and alcohol sector or nothing from the drug and alcohol sector and really good support from mental health, and so it's that that families say to us they get very confused and concerned that there's a mix of supports or they don't know what their rights are in each of the areas.

PROF WHITEFORD: So we've identified that, because many people did tell us that. The recommendations we've made about how that could be improved; was there anything in addition to the recommendations we made which could help?

MS GRIFFITHS: As far as families go, I think it is more about family inclusive practice, particularly in the drug and alcohol area that in Tasmania families say is either non-existent or it's very slim, so it's about ensuring that there is a family-inclusive practice set of principles

and application in both sectors, so families can understand that they're going to receive the same level of support for both.

PROF WHITEFORD: I guess we've not speaking specifically, I suppose, about the drug and alcohol sector. We understand the issue about comorbidity, not just drug and alcohol but, you know, physical comorbidity in other areas. Is it because the information isn't made available when asked or, you know, is it that carers in Tasmania are excluded because of issues around privacy or whatever the barriers are that we haven't been able to overcome?

MS GRIFFITHS: Are you asking around the drug and alcohol area or - - -

PROF WHITEFORD: No, around mental health.

MS GRIFFITHS: Around mental health.

PROF WHITEFORD: Where there is any comorbidity, I suppose.

MS GRIFFITHS: Okay. I think it's around information, and I think it's around not knowing what the signposts are that take you on the journey. The signposts that take you on the journey around mental ill health are over there and the signposts that take you on the journey elsewhere are over here. There's nothing in the centre that sits with the family and says, 'Okay, these are the circumstances.'

PROF WHITEFORD: Bring it together.

MS GRIFFITHS: We need - yes, yes. So there's not a whole of family approach to the issue. We tend to have bits and pieces happen to families in Tasmania.

MS ABRAMSON: Just following on from that, do you have a preference for what layer of government should be providing the support, because in our model we've talked about regional commissioning on the basis that we want people to plan locally and commission locally for the services of that population, but you've very clearly articulated the mismatch of trying to bring all these together.

MS GRIFFITHS: Yes.

MS ABRAMSON: Do you have a view about who should provide the services, from a government perspective?

MS GRIFFITHS: From a government perspective. I'll go back to what happened in the disability sector. I had experience around that in Tasmania when we closed down our institution, Willow Court, where the state government said, 'We're no longer providing services. We're going to hand service provision over to the community sector,' and that happened, and I was very involved in it. In the mental health space, I'm very confused about why the state government provides somethings and then the Federal government have this and that. I get very confused in trying to map out what's what when I'm talking with families. It would be so much better to have more clarity about who provides what, who funds what. I don't have a preference, but more clarity, and perhaps we may need another look at the whole system

to say, 'Well, these sorts of supports will only be funded by blah and other more acute supports are only provided by XY.' Certainly on behalf of families, more clarity is required.

If I find it hard to make sense of the space, I certainly see that families do and will continue to do so.

MS ABRAMSON: The other thing that I was very interested in is you talked about advocacy, non-legal advocacy, and we do have some recommendations around the Mental Health Tribunal, but clearly what you're thinking about is broader, so I'm interested in understanding that.

MS GRIFFITHS: I'm thinking about advocacy support for families. More than often, we come across families who are really struggling to understand systems, to understand XYZ, and to have someone walk alongside families when they're in that, you know, confusion, sometimes the journey for families can be years and years, and I certainly note that we have funded advocacy for consumers. We do not have that for families, and we're asked all the time by families, 'Will you come and help me write this letter?' or 'Will you come to this appointment with me?' but we can't because we don't have the resources.

So it's that kind of thing would be really really helpful for families, to sustain their capacity to continue the care that they provide, and in my jurisdiction, that doesn't exist.

MS ABRAMSON: Are you thinking of putting in a submission?

MS GRIFFITHS: Yes, we will be.

MS ABRAMSON: Because I would encourage you to particularly make that point to us. The other issue that you spoke about was accessing superannuation. The Commission has done a great deal of work in superannuation, and apologies to your colleague, Ms Beasley, who spoke before. I meant to ask you further about super. What is the issue?

MS GRIFFITHS: Okay.

MS ABRAMSON: Is it the super laws don't allow for access to the super?

MS GRIFFITHS: Okay. We have - I could think of half a dozen families right now, all women, middle age, who have had careers, who have had to leave their job to carry out some caring responsibilities over a number of years, so their super has ceased. Over a number of years they've been providing support. Some find it impossible to get back into the same career because if they're a GP, for example, they've missed so much that it's really hard to get back. It's that that concerns us, and it's particularly happening to women, and I am concerned that if we are relying on the informal support that in particular women provide, this issue is going to become more so. What can we do in order to protect those people who are providing that support for their long-term income into the future? And if the person they're supporting after three or four years is going really well and they've been able to recover to a point where they can live a meaningful life, then the carer is left going, 'Well, hmm, what about me now?' and some people have had to, you know, go into the kind of work that they don't really want to. They'd rather be back into their profession but haven't been able to.

MS ABRAMSON: It would be really useful in your submission if you could outline those circumstances because I think any thinking would not be around - I mean, I can't speak on behalf of my colleagues, but the government funding the super. It would be more like, what are the transitional programs that would help carers get back into the workplace.

MS GRIFFITHS: Yes.

MS ABRAMSON: And that certainly would be a space we would be interested in.

MS GRIFFITHS: Thank you. Thank you.

MS ABRAMSON: Thank you very much.

MS GRIFFITHS: Thank you very much.

MS ABRAMSON: Thank you.

PROF WHITEFORD: Thank you.

MS ABRAMSON: We're running a bit ahead of schedule, but if the Royal Flying Doctor Service Tasmania are here, we'd like to hear from you. If you'd be kind enough to announce who you are and who you're representing, and I expect that you might have a short opening statement. We have some water for you on the table. Sorry, we've called you up early.

MR KIRWAN: That's all right. We're enjoying the discussion.

MS ABRAMSON: We've given you an earlier landing spot.

MR KIRWAN: John Kirwan, CEO of the Tasmanian section. Nicole Grose, our manager of primary care. Can I just make some - - -

MS ABRAMSON: Absolutely.

MR KIRWAN: Yes. Just first of all, I'd just like to endorse the Mental Health Council of Tasmania's submission earlier today. We're a member of the Mental Health Council and we think they're doing some innovative work.

I won't speak to aeromedical, because I understand the federation may make a comment themselves and we published them in that work last year or earlier this year. Earlier this year now - that goes to the aeromedical side. I'll focus on our primary care in Tasmania specifically, and Nicole can go to the detail because she manages the program, so I said, 'I'll do the easy stuff and she can take the hard questions.'

So just a general comment. I enjoyed the report. I wouldn't say I've read it all in detail, so the comments are not meant to be critical; more a case of emphasis, and some of your earlier responses and questions have already picked up some of those, so I'll try not to be too duplicative.

One area that I would make a comment on, and I think it's implicit in the report is one needs to actually define what mental health is, and I know having worked in an acute hospital there was often, dare I say it, demarcation disputes between various parts of the medical profession, let alone within parts of psychiatry and others, social work and others, as to what was mental comorbidities, we've already touched on, and others, and I think there is an issue.

I say that particularly because my interest now is remote and rural. That's our areas of practice, and it is often not a clear medical model. It is not a case of where you can have a psychiatrist or a psycho-geriatrician or others, and so we actually do need to work within what is in scope, and again I listened to your earlier comments. We would always favour a more holistic approach, particularly in remote and rural areas that picks up physical health, emotional, social wellbeing, but particularly early and again, you commented on that in respect to the public comments. We are cautious about a model that starts with a mental health diagnosis rather than it starts more upstream in those sorts of areas.

So one of our programs we can explain doesn't require a diagnosis, so we have a mental health staff and youth mental health staff in the field. They just need the referral, and that referral pathway can be from various different pathways.

Not surprisingly from general practice, a lot of it, but we also find that a lot of people are not keen on being - because of the stigma, having a mental health diagnosis and what does that mean.

Holistic care is very important for us and that goes back to how we were founded over 90 years ago and particularly working in what the Commonwealth would call areas of market failure, trying to be as holistic, trying to fix what we are seeing as much as possible then and there, and that's the model the RFDS still tries to have across Australia to this day rather than a medical specialist model.

I would make a comment, and you just touched on it about your regional purchasing. I worked in government and health system for over 40 years now. I caution about top down reform, because I don't think it's worked, so if you are going to reform I think there has to be, as we just heard from either the families or the carers, peer workers, there needs to be pressure from the bottom up, and particularly Canberra led top down reform, and I say that because the trickle-down effect to remote and rural areas of a one size fits all, I really do caution in some of these areas, particularly when you can't necessarily in early days be all that clear what you're dealing with or what the underlying issues are.

Timely access is critical in our view, and we are seeing that time after time, particularly although Tasmania is not as disadvantaged when it comes to GP coverage as what some of the mainland states are, particularly more remote areas, but we are seeing increasingly more and more locums as GP positions aren't being able to be filled, and not necessarily GPs with an interest in mental health. So the GPs are only locums, don't even know what the existing NGO and other services are, pathways become clouded because they're only there for a week, sometimes shorter, and what does that mean?

So again, that pathway, and I noticed in one part of your report, if I remember it properly, I did

notice a focus on the GP has been critical. We would say it's probably more critical earlier on in respect to those referral pathways, and as I said, we accept referrals from pharmacists and from others.

I should probably then touch also a little bit on the workforce. I've come to a view, and probably not a popular one, that if we expect to see our traditional six-pack of mental health professionals in some of these remote and rural areas, I think you're dreaming, to be blunt. We probably need to look now at a new model of care, and in my speaking notes I sent through, there's a new associate degree at the university here that actually does potentially present a more generalist model at a level below the degree level. Now, I know that's heretical to a number of the professions, but I do point out the success of Aboriginal health workers led by the medical profession when they actually realised that we weren't going to have doctors and nurses in all of these communities, so at least a presence to help in early detection, prevention and referral.

So again, if we're looking about reform, I think if we think we're going to stay with the traditional workforce in remote and rural areas, we will be unpleasantly surprised. And again, we published some work this year that showed what the workforce is looking likely to be in the next 10 years, and in the mental health and allied health spaces, and that cuts across disability, aged care and acute care as well. It's pretty skinny in Tasmania for a range of reasons, e.g. most of the allied health professions aren't trained here, so we've got some real challenges if we want it fitting a model that may work well for a big city into an area where there just isn't - they aren't there.

MS ABRAMSON: We're really interested in seeing that data, if you'd like to send a submission.

MR KIRWAN: Yes. I understand what you're saying on pooling and funding, coming back to that, but as someone who in his earlier career was in fact a purchaser commissioner in Western Australia, my experience is unless you quarantine some of that, what will happen is it will triage itself to the highest area of need, and in Tasmania the acute mental health area is struggling significantly, so if it's all in one bucket, as happens in a hospital today or a health service today, there's not much that goes out on a preventative health program because the ambulance ramping today, the elective surgery waiting list today, will get the priority politically and otherwise.

So pooling does make at one level, particularly joint commissioning, mapping, making sure services are going where they should be, does make sense, but the reality, when put into that system, you need to have those stop gaps and guarantees, in part because the remote and rural people don't get a voice very easily, and as we know they've got one sixth access to services in mental health, so we need to address that.

The comments on social determinants of health I think was encouraging, and I think we need to expand that forward again. Your commission can't fix that, but we do have issues here. Intergenerational unemployment in youth, under-employment, housing and other areas like this, and if we are really going to address some of these things, intergenerational issues, they are not easy but they do need to be named up and we do need to start working our way through them.

I'm not too sure when you mentioned the role of teachers. It may or may not be. We have youth mental health workers, which Nicole can explain, that work in the schools, so whether they are a better option. I just have some concern about putting too much onus on teachers in respect to maybe early detection, but some of the lead roles I'm not too sure that's quite going to be the best response.

The generalist model I'll leave Nicole. I just would finish off in respect to just coming back to the workforce, and again, looking to different models going forward, and again, we have had success within a generalist model of rural health worker, physical health workers and mental health workers working together as a team and working as closely as we can with the GPs. That is, although a number of them aren't qualified, we haven't employed them as social workers or psychologists but as generalists, and that's fairly important, I think.

I think probably social participation in these areas is probably the last thing I would touch on. That is to say I think we don't probably see, although you speak to experienced practitioners and of course they'll say they do practice social prescribing, but if you've got a very busy GP practice that's effectively operating on six-minute blocks to be able to push through the numbers, their ability to sit down and investigate and work out other support systems that the client or the patient can actually have is very very difficult, even if it's a referral to a Men's Shed or others, they're having to pump it through. But the system under a fee for service payment system does not encourage that type of a social prescribing model that we see probably better defined in the UK and other places.

MS GROSE: Thanks. As John said, our model is based on a holistic model where we support people socially, emotionally and physically, so anyone that gets referred to us or self-refers into the mental health space, we also support them with their physical health with an exercise physiologist, OT or similar, and we're getting really good health outcomes from that.

We find with a lot of our staff in the rural areas referral pathways are very difficult, so we need to be more generalist to be able to support those people and not necessarily need to refer on to more acute care. We do work closely with GPs and that's working very well.

Comorbidity is - 90 per cent of our clients come to us with comorbidities. Mental health and physical health go hand in glove, and as Reverend John Flynn said 90 years ago, the mind and body are integrated yet inseparable, and we see that all the time and that's how we work with the program.

PROF WHITEFORD: There's quite a bit there. So just for my clarification, obviously there's a lot of work that's not aeromedical. Can you just run us through that so we just understand the space that you work in that's not aeromedical?

MR KIRWAN: So the RFDS is a primary care provider, including our aeromedical primary clinics and other areas, but we're probably best known for our aeromedical retrieval work and transfers. That is nowhere near the majority of our work. In Tasmania we have a contract for aeromedical service for the ambulance service, so that's retrievals and transfers, so it doesn't deal with clinics. So each of our six sections is somewhat different, so it does depend on what we're funded for by either the Commonwealth or indirectly the Commonwealth or in state

contracts. So we are a federation under one brand, but we are a different model.

However, the common theme is primary care, of which we would see - we include mental health and dental health. The dental health is a whole challenge in itself. And should I say in this space as well in respect to emotional and social wellbeing and for people who have got no teeth or rotted teeth, social disadvantage, exclusion, not applying for jobs, not leaving the house and all of those things. So that's a whole separate topic as well.

We here have a primary care service and that includes our dental team, so we have on the ground, not flying, about 35 staff in two different models. Where they're place based wherever possible the staff live and work in the community. Where it's a mobile service which literally means that they work in one area and move to another, they'll come in Monday morning and come back Thursday night. Sorry, they'll leave Monday morning and come back Thursday night. Be away four days, three nights in the community they're working in in that week, so we try and do week blocks in those areas.

PROF WHITEFORD: And the employees you have within that service? What types of professionals would you have?

MS GROSE: Yes, we have clinical psychologists in some areas, we have social workers, mental health social workers. It just depends. We really try to recruit locally as well to help the whole community and the economy and everything else, so it depends on what - it changes depending on what community.

We also have exercise physiologists as well, physiotherapists.

PROF WHITEFORD: Okay.

MS ABRAMSON: Can we get some data on the types of services that you provide to people with mental illness, and what types of services? That would be really useful for us.

MS GROSE: The types of service is we provide support for adults and that's in eight different rural areas. We also provide support for youth aged between eight and 16, and that's in six rural and remote areas. So the youth program is only very new. That I think would be three or four months on the ground, and the adult services have been on the ground for two and a half years, and we're fully subscribed in all of those areas and we have wait lists in quite a few as well.

MS ABRAMSON: How does the youth program relate to headspace, which is quite a presence in mainland Australia?

MS GROSE: Yes. So when we got the funding for the program, we worked very closely with headspace and Cornerstone to ensure that we didn't duplicate services and we filled the gaps as well, so we worked closely with headspace here to ensure that the areas that we went to, that they couldn't provide the service. Once again, you know, there's limited funding so you can only go so far, so we worked - and we worked at an early cohort as well. Our program you don't need a referral and you don't need a diagnosis. So quite often we will be the first point of call, and then we can refer on to other services where necessary.

MS ABRAMSON: Could I also ask you about suicide statistics, or attempted suicide, to be honest; whether in fact it's much higher than what we're actually seeing from the data that's reported from the hospitals. Like, there's an under-reporting in a busy emergency room. It's not treated as an attempted suicide, and the reason that we're - well, we're interested because it's such a huge issue, but also we're strongly of the view that there needs to be support after people leave hospital on an attempted suicide, but of course if a hospital is not recording that actually was an attempted suicide, then they're not even going to be in the pathway for additional services to be provided. So do you have any experience in that area?

MS GROSE: I know from working in small communities, everyone sort of knows everyone or knows what's happening, and I think it's under-reported definitely.

MS ABRAMSON: Yes.

MS GROSE: I don't know exact data, and a lot of times the families don't want it to be identified as being a suicide or attempted suicide as well, so it's stigma once again associated with it. But we definitely hear a lot more about it in rural and remote areas because I think it's the small communities that we're working in.

MR KIRWAN: If I can just respond, in our cardiopulmonary rehabilitation program, stage 3 rehabilitation, so it's not rocket science, but working with people who are post-event, we've had significant success in the north of the island in reducing the waiting list at the LGH for those cardiopulmonary areas and improving the health outcomes, so follow up after an incident, appropriate follow up after the incident, I think I would see no reason why that model wouldn't and shouldn't equally apply in mental health, but it is again of making that accessible, making that comfortable and what we found when we had an evaluation done by UTAS, one of the things that people reported most was the saving of not having to spend money to drive into a regional centre. And for some people that was \$300 a month if they had to come in for three sessions, in the end they just didn't.

MS GROSE: Or in the cardiopulmonary space as well, as John said, we do phase 3. A lot of people that have a cardiac (indistinct) can have their license taken off them for up to six months, and if they live in rural and remote areas they can't get in for the rehab and then it creates that anxiety and it's stress on the family members as well. Yes, so community-based follow up would work well, I think.

PROF WHITEFORD: Can I just go back to your funding issues, so your primary care, you mentioned there are multiple sources for your funding. Does that include - like, are some of your providers able to bill the MBS? Is that part of it or is it contracted and salaried staff that you have?

MS GROSE: No.

MR KIRWAN: Our two programs, one is through the chronic disease funding from Primary Health Tas. We were successful in tendering across four chronic diseases of which mental health was one of them, and so that again reinforces the holistic approach that we work in that area, and more recently through Commonwealth direct funding to the Royal Flying Doctor

Service nationally was a mental health program, and then in consultation with Primary Health Tas and the department, and others, that's where the mobile youth service was seen. Again, we tend to work in areas modified Monash 5 and above, and in areas where we try very hard to avoid any duplication with existing services. Having said that, often people will say that they provide a service in an area, not just mental health, but we'll find that that's once every three months.

PROF WHITEFORD: Yes, sorry, I'm wondering whether the data there for, on the services you provide, is captured in anything statewide or national, aggregation of mental health?

MR KIRWAN: That's an issue for the higher FDS, as you're probably aware. We're one of the only two block funded services, us and Aboriginal Medical Services. So our data isn't normally captured in MBS, PBS type capture, because it's fee for service, that's a nice data set to then pull out, but you don't want to (indistinct) or whatever it is, but we do capture all of our data, in the minimum data sets, and that's the word that I referred to earlier that's come out of the federal office, by extracting it out of our medical records, we use MediRecords, assuming everyone has entered their medical records, appropriately, which is an ongoing challenge, although now we're accredited, it's an issue that we now audit against, to maintain our accreditation.

So the data is there, but not – to answer your question, not automatically captured in those other data sets. That's why some of our national reports, like our medical work, we're the only ones that hold the data set.

PROF WHITEFORD: Yes. I'm just looking at the team over there, we want to make sure we've got that coverage. Not just, obviously, for Tasmania, but what you've told us about the national - - -

MR KIRWAN: It will be – I mean, because our staff are salaried – having just said that, I think most of them are – but also on the mainland, so we don't work in the Medicare funded system, and so the data is captured separately from that, which often means where we're active, it's under reported, if you're only using those traditional data sets.

PROF WHITEFORD: And I know you're not covering the aero-medical retrievals that you do, but we – while we have you here, we're going to take advantage of that. So, do you have anything to tell us about with respect to the transfer of people with mental illness, where they're being transferred via RFDS, and if you want to take that on notice, that's fine. But I guess, we're trying to get a handle on that, because we have heard that that can be quite a challenge at times.

MR KIRWAN: It can, and it is, as someone who comes from Western Australia, originally, I'm conscious of those challenges. There is the report, that we released aero-medical retrievals for mental health crises, and the level of support. If it's not in that work, I'm sure that Dr Fergus Gardiner, who's our epidemiologist in Canberra, can probably help with that area. So, if we've got it in a data set, it will be available, and again our new National Executive Officer, Frank Quinlan, so again, those areas are - - -

MS ABRAMSON: We're very familiar with Frank.

MR KIRWAN: I'm sure you are. Again, I think that – I was surprised when this national report came out at some of the figures.

PROF WHITEFORD: Yes.

MR KIRWAN: As to how high it was, because I know there's normally a reluctance in transferring mental health patients - it goes to issues of sedation and escorts and things like that. But if you've got no choice, you've got no choice.

PROF WHITEFORD: Thank you. Sorry for interrupting.

MS ABRAMSON: Thank you very much. Thank you.

PROF WHITEFORD: Thank you.

MS ABRAMSON: Could I ask, I'm assuming our next participant's here. Ms No, from Victims of Psychiatrists. If you'd be kind enough to take the stand, or take a seat, announce your name, and who you represent. And I'd also invite you, if you wish to do so, to make an opening statement.

MS NO: Ms Initially No. I organise for Victims of Psychiatrists. We're a collective of people, it's also a generic term, for people who have been through forced psychiatry. We organise protests, and also petitions, and support people who are suffering the harms of forced psychiatry. We also intersect with a number of marginalised, oppressed groups of people, including people who have allergies, sensitivities, to petroleum based substances in therapeutic goods.

Now, to read this draft report, Victims of Psychiatrists have to replace the hate speech; that is, the mental health jargon used by our government officials to attempt to justify the persecution and torture of victims of psychiatrists. Hate speech causes a barrier in being able to read such a document. Mental health hate speech is a threatening reminder of previous and current violations upon our people, and gets in the way of doing the job. For those who have, or are being subjected to forced psychiatry, rolling out more mental health associated propaganda, in workplaces and schools, will only make matters worse.

Mental health propaganda also ignores obvious workplace hazards that cause difficulties which often get put in to the unhelpful category of mental health issues. Most especially, the accumulation of toxins in the air space, primarily caused by personal products and poor ventilation. To expand mental health training, into work places and not look at any kind of air quality control is really dangerous, and placing mental health issues on people who are suffering from prolonged exposure to poor air quality is a violent thing to do.

To then expose such a person to even more toxic air spaces in hospitals and exerting coercion and force upon a person to take chemicals that they are already sensitive to; psychiatric drugs that carry a warning of drowsiness, inability to operate heavy machinery, that's not going to contribute to a person's productivity at the workplace - - -

PROF WHITEFORD: Can I interrupt you for a second, sorry?

MS NO: - - - where better air quality and better regulation fragrance products would have done so.

PROF WHITEFORD: We've got the submission you've made, and we certainly got that. Would it be better if we could ask you some questions about it, to associate things we're not certain about? Because we've got that and we can make any of it available in the public submission space.

MS NO: Could I have five minutes just to outline this?

PROF WHITEFORD: Sure, absolutely. Yes.

MS NO: Emergency medicine, intention to treat and audit are used as reasons to forcefully experiment on victims of psychiatrists in invasive, cruel, life destroying ways. A range of exploitation is then turned into profit and loss statements. So this is point number two: in the same way – this is done in the same way there profit and loss statements as laboratory animals are financially costed. Only the victims of this exploitation are said to be the cause, and any costs of the organisation that they incur, including wages, are put upon the victims of psychiatrists, like we're totally to blame for all these costs.

Victim blaming is not an unusual tactic in an exploitation racket, and it's historically common, yet it's obvious people held in servitude to psychiatrists, who are held by force, who are not paid, who are being violently exploited by the mental health system are the economic boom. Unpaid laboratory specimens, gosh. They're not permitted to leave, and that's a disgusting thing for a democracy to allow, and I'm sure it's not what Australians want to fork out 130 billion per annum to harm us, and pay the psychiatrists for. So I'm asking for strong scrutiny of mental health companies that wish to expand through government grants. I think that's what's needed.

Particularly companies that force their products, procedures, and programs on people, and utilise government legislation to deny people the right to refuse; that use coercion to get people to do their programs, or voluntary work at their services, in exchange for perhaps a little bit of mercy from the maltreating mental health team.

MS ABRAMSON: Ms No - - -

MS NO: Victims of Psychiatrists – can I just finish? Victims of Psychiatrists have had their livelihoods stolen by the mental health industry, and the government that legislates and invests in this. At the point of vulnerability, when we were lured in by the idea of talking things through with a psychiatrist or psychologist, and when we were maltreated, the mental health personnel would just not let us walk free. Took away our independency, destroyed our careers, and while torturing us with their products and procedures, demanded we agree with everything that the psychiatrists dictated, that the products that retarded our intellect, physical abilities and creativity, that also disfigured our attractiveness, destroyed our fertility, was something benevolent that we had to agree we need, or we'd never be free from arbitrary detention, or in the toxic psychiatric ward.

And we found if we kept trying to speak out against this, psychiatrists would increase their torturous products, procedures, programs, and tell us that putting us to sleep 22 hours a day with forced neurotoxins, made us better. So, an expansion of mental health associated industries is not economically viable, or ethically suitable to a democracy. That's the way we said, as first person people who have been subjected to this. I'd like to see these industries survive when people have the right to refuse. That would be a good test of true need, competition, productivity, as well that insulting charitable status, claiming the necessity for the violence they inflict upon us.

MS ABRAMSON: Thank you for your presentation. I wanted to ask, on an area where I think we have common ground, which is about legal advocacy, for people prior to compulsory treatment. The Commission has made a recommendation where we've said that people need to have access to advocacy, whether it's a legal – a lawyer, or it's other advocacy services. So, what are your views in that area? Because I understand that you're keen to see more support there too.

MS NO: Yes. In Victoria, and other states as well, the availability for legal aid is very low, and legal aid also need a lot of time to be able to set precedents. So it's basically, they're tackling government legislation that's very, very old. The last Royal Commission in Victoria, for instance, was in 1886 on mental health - - -

MS ABRAMSON: Although there is one currently running - - -

MS NO: There is one happening now, but we have conflicts of interests. Two psychiatrists on the board. No victims of psychiatrists, and, you know, I was not heard at that, so I thank you – I thank you for hearing us here now, and I was not able to make the Melbourne one, because we had a fellow person who stands at parliament with us to change the legislation, taking in by psychiatrists. So we have to do enormous amount of work.

MS ABRAMSON: What's the legislative change that you're talking about?

MS NO: The right to refuse. It's like the right to refuse a shop. It is just a shop. It's got products, procedures, programs. We should have the right to refuse that. It's logical, and to have an industry that, you know, is able to grab people to say, this person, even though they don't want us, government, you're going to pay money for us to exploit this person for human research. Now, that's another thing, is that they're not even really following the legislation, in Melbourne, effectively. They are actually running mental health tribunals like a compliance test. Like politics, and an opinion on being mentally ill. And that's not legal under 4.2.

MS ABRAMSON: Well, the thing that, as I've said, that we've concentrated on, is providing support at the time that the person appears before a tribunal.

MS NO: It's good for legal aid to do that, but if they're just running the mouse wheel, right? But for most of the time, it's only ITOs that are lucky enough.

MS ABRAMSON: ITOs?

MS NO: Yes, sorry. Internal treatment orders.

PROF WHITEFORD: Interim.

MS NO: Sorry, yes. So, they're people that – and even then, they won't necessarily get a lawyer. So this is like, really under representation. But here you've got a whole lot of people, you know, wanting to refuse this, and a government's saying, 'No, we're going to let these people,' and no oversight on what these psychiatrists are doing when they're breaking the law.

MS ABRAMSON: So, your interest is - - -

MS NO: The tribunals are rubber stamping things.

MS ABRAMSON: I understand what you've said to us. So your interest is in the appearance before the tribunal, accountability of the tribunal, and the tribunal people, and as participants as well.

MS NO: Yes. I'm also interested in – I mean, people have needs in society, you know? People go through grief, and they – they want to be able to see a counsellor, but they don't want to be dragged in forever into a – because that's the thing. Somebody goes to get this need, and then suddenly, they – a lawyer can't do anything.

MS ABRAMSON: What would have made a difference to you, when you're thinking about your circumstances? So, what would the system – like, I've understood what you've said about the ability to refuse treatment, but are there any other services that could or should have been available?

MS NO: It's about, if a person's being harmed by somebody, so there's many, many situations. So for instance, I mentioned the one with the toxic products. That's really under acknowledged, by both the medical and government as well. So there's a whole group of people that are – Anne Steinem does wonderful research on this. She was a civil engineer, but she also suffers from this condition. We've also got author Kate Greenfall, who talks on it as well. So they're people well-known.

But a whole lot of people, over 35 per cent. And we're going to workplaces and, you know, feeling horrible and all that. There's also domestic violence stuff. Organised crime; people can't talk about this stuff, you know? That's really scary to people. So I did work in peer support for a bit, right? So many different things happen to people and they can't even talk about those things that they need justice for, or those things that they need justice for they can't get that, but the worst thing of all is they can't get justice for a psychiatrist violating them.

And that's just – I mean, that the government is violating them, and their population is saying, 'This is help and this is care.' So insulting, so life destroying. People can't work on these drugs, and in your Productivity Commission, you're saying, 'Well, let's make them even,' you know, 'less cost to our government.' These people are being shut down. You know, people with brilliant, you know, abilities, being electroshocked to the haemorrhage. You know, these drugs that are being forcibly injected into you. Causing epilepsy and - - -

MS ABRAMSON: I think – we’ve heard what you said, and - - -

MS NO: And then they want to do secondary research. It’s disgusting.

MS ABRAMSON: Can I just say, look, thank you for bring it to our attention, thank you for being so passionate. And I think my colleague has a question.

PROF WHITEFORD: So just quickly, when you say that the law’s being broken – so when there’s legal representation at a tribunal, is it that the lawyers aren’t doing their jobs, or is that the legislation within which the lawyers are working? If we made legal advocates available, the legislation’s got it wrong, from your perspective?

MS NO: The legislation should allow the right to refuse, and then – we don’t want, like - - -

PROF WHITEFORD: Sorry, can I just – no, sorry, can I just – give me a chance. So - - -

MS NO: - - - 13,000 forced orders in Victoria - - -

PROF WHITEFORD: So, the legislation should have the right to refuse. So, are you saying that therefore there should never be a situation when a person could be involuntarily treated, ever?

MS NO: No. If Australia has signed and ratified the U.N. CRPD, the Rights of Persons with Disabilities. That clearly states that we should have the right to refuse medical treatment. And how can you say a blanket medical treatment is right for everybody?

PROF WHITEFORD: No, I just – my question was, in your opinion, should there never be a case where someone - - -

MS NO: Absolutely, absolutely.

PROF WHITEFORD: Okay.

MS NO: If it’s a police matter, it’s a police matter. But if it’s a psychiatrist judging my mentality, as a woman, and it’s a male psychiatrist, and - - -

PROF WHITEFORD: No, I heard your answer. I heard your answer, thank you very much.

MS NO: I mean, excuse me, this happens way too often. And women are persecuted by these monsters. They’re also sexually abused by these monsters. In fact, on that attacked me is now in gaol. So, I’m talking a psychiatrist. So this is – these are not people to be trusted. They’re not people to be expanded, you know, for us to give more money to. They’re people that really need to be investigated, not only state-wide, but under 8.2 and 8.3 of the Responsible Research Code, because audits and intention to treat, and you know, codes to forcefully exploit people for human research – it’s really dirty.

MS ABRAMSON: Thank you, Ms No, and thank you for speaking so passionately about it.

PROF WHITEFORD: Thank you.

MS NO: Thank you for letting us have this spot today, and people of Tasmania. Launceston.

MS ABRAMSON: Thank you. Mr Floyd? I believe you'd like to speak. If you'd be kind enough to state who you are and who you represent, and if you have a short opening statement, we're happy to hear that.

MR FLOYD: Thank you very much. Sorry, the last – well before seven years ago, I had no idea about the massive criminal activity of psychiatrists in our community. I spent seven years as a VCAT, QCAT, Supreme Court, County Court advocate, pro bono, spending my life now every day working to help people slaughtered and killed and damaged by psychiatrists.

MS ABRAMSON: I'm sure, Mr Floyd, that our staff have already mentioned to you not to mention any names of any individuals.

MR FLOYD: Of course.

MS ABRAMSON: Thank you.

MR FLOYD: Now my name is Glen Floyd, pro bono advocate for all those court jurisdictions. I got the United Nations to order Australia to stop electrocuting a public case, Garth Daniels in Queensland. It's publicly known out there, and there's no suppression order on Garth.

So I help vulnerable persons massively harmed by widespread, fraudulent psychiatry in four recent and current cases, and I'm the convenor of the Australian Abolish Psychiatry Party. Twenty-five years senior management person in Telstra, top 3 per cent. Ran a charity for the last seven years and ran a recruitment business. I have worked my entire life in a community contributing to those areas for the last seven years. I had no idea this massive death and morbidity was taking place, caused by psychiatrists.

Widespread, fraudulent psychiatry kills 80,000 Australians per year. There is a current ABS stats, every year, 80,000 Australians killed by psychiatrists and psychiatrists' drugs. That's the morbidity levels.

MS ABRAMSON: Excuse me, Mr Floyd, do you want those taken as formal submissions?

MR FLOYD: Yes, I'll hand on in to you at the end of my speech, if you like. That is the ABS statistics, okay? So they're current statistics, but that's nine years old. It was 76,800 then. It's now over 80,000, killed by psychiatrists and psychiatrists' drugs. They're the two categories of where these massive deaths are occurring. You stack up those 80,000 corpses head to toe, they would run from Melbourne to Bendigo, an hour – two hour drive away. You'd just look out the window running at 100 kph and watch dead corpses for two hours, killed every year.

Widespread, fraudulent psychiatry kills 80,000, as I said. There's the ABS statistics. Psychiatrists are humanity's deadliest pandemic scale predator. These people are being killed by psychiatrists and their drugs. Heroin drug pushers only kill 750 Australians every year. Psychiatrists' drugs kill 10,700 per cent more than heroin drugs.

MS ABRAMSON: What would you like to see done, though? What would be your path to reform?

MR FLOYD: My path to reform will come at the - when I finish making these points. It's widely held by lauded professionals inside and out psychiatry such as Peter Breggin, Niall McLaren psychiatrists are that psychiatry is evil in the house of cards. These are psychiatrists saying this. Adjunct professor Dartmouth College Patricia Deegan, clinical psychiatrist, states that, "Psychiatrists dehumanise and depersonalise to the point of spirit breaking, destroying social justice and the right to humane treatment and rehabilitation," as initially now has just stated. A person telling you she's on the receiving end of this.

Psychiatrists destroy lives, families and productivity. The mass death morbidity regime has no foundation or basis whatsoever in psychiatry. It's fundamental fraud for financial reward, and clearly earmarked with such by the following factual statements. Psychiatry is purely fraudulently concocted, pseudo medical conditions. They do not exist. People suffer massive emotional traumas in their life, but they do not have a brain disease, and there's no cause shown whatsoever. There's no biological markers or pathogens shown for bogus conditions such as schizophrenia, et cetera.

These conditions cannot be tested to be existing, and toxic drugs are put into people for them, like you're giving a vaccine for a known disease of measles, when the forced lethal neurotoxins, example, carfentanil, 10,000 times stronger than morphine, yields no biomedical impact on the person, then psychiatrists make fraudulent condition statements such as, "The person's got treatment resistant schizophrenia," and push more drugs, that are purely concocted with no evidence base whatsoever, you know, drug resistant schizophrenia.

No other medical branch of evidence does this. If you've got a pathogen, you're given a medication that can kill the pathogen. There is no known biological marker for any of these psychiatric fraudulent diseases. They are purely concocted treatments with no validity, no reliability and no disease cure whatsoever. All bogus diagnoses classifies the person as a danger to themselves and others, and no substantive evidence shown whatsoever is given to show this fact that they're a danger to themselves and others, just capricious statements. Totally removes the person from society.

For example, in Victoria, there are 115 per cent more forced orders in Victoria than New South Wales. Sister state, same demography, and the commissioner in Victoria at the moment, Bernadette McSherry said, "This is lamentable, it cannot be." Victoria's got double the rate of psychiatric forced admissions. Same state. It's statistically impossible. It's fraud. It's psychiatrists pushing these diseases for money.

Out of the 3,100 deaths in 2017, 86 per cent were caused by lethal new toxic psychotropic drugs. Only 14 per cent were people who suicided without these drugs. Most deaths of psychiatrists' patients, that's the 80,000, are not due to physical health conditions. Coroners never show the lethal neurotoxins causing these drug reactions, suicide deaths, which is shown on the manufacturer's black box warnings.

There's a massive conflict of interest inherent in the racketeering psychiatry paradigm, whereby a vast financial gain in two direct areas falls directly to psychiatrists and other players to deliberately, fraudulently diagnose non-existent mental health disorders for massive financial rewards. They are a vast one, salary funding cabal of corrupt, racketeering psychiatrists, social workers, nurses, hospitals. They're taking money to force brutal and cruelly inhumane and degrading torture, which is what the UN calls this: a clear violation of our UN – United Nations CRPD. And you recommend more. The death rates are massive.

MS ABRAMSON: Mr Floyd, we're happy to take written submissions. I'm a bit mindful of the time and allowing other people to have their say.

MR FLOYD: I won't be long. I understand, I won't be long. So I spoke to Tasmania's psychiatrist general Aaron Groves in 2015 in Melbourne, and he got up after I made this same submission. He said there is evil in psychiatry. This is the Tasmanian psychiatrist – general psychiatrist – he was in Adelaide at the time, and there is evil.

Now the specific money driven diagnosis, deliberate fraud is monumentally widespread where psychiatrists are empowered by all Australian mental health acts to make whimsical, unsupported, capricious specific bogus diagnosis of non-existing mental illness, and cite the following fraud statements with no referenced definition whatsoever. The diagnosed person is a danger to himself or others. The diagnosed person is at risk of deterioration. The diagnosed person does not have the capacity to accept or understand their mental illness, and the person is thought disordered. All of these are unsupported 50 per cent of the time. No evidence, just the statement by the psychiatrist.

The United States American Psychiatric Association says that the predictability rates, even in the most robust system, if you use, you know, particular registered scores to try and predict dangerous to – probability, dangerous to self and others – it's 33 per cent. So it's a 66 per cent failure rate to be able to predict the danger to herself and others. This is the best you can do, even in the most severe criminal cases. So this is – these psychiatrists would be better flipping a coin. They'd get it right at least half the time. These are hideous attacks on people. Now I'm nearly finished.

There are massive amounts of fraud statements all across Australian psychiatry. I'm dealing a case at the moment where a woman is declared she's at a risk of – herself to others, a Victorian VCAT hearing, because she's sending group emails. Now that is spam at the worst. Horrific diagnoses, and the psychiatrists are doing this all the time.

Okay, and no evidence base whatsoever, and The Lancet says that in 50 per cent of diagnoses, there is no evidence base whatsoever for this alleged danger to themselves and others. Now a saltatory metric to describe collapsed productivity is these drugs lead to 26 years' death – rather death 26 years earlier than people not brutalised by psychiatrists. It's utterly puerile to attempt to describe the obvious massive productivity loss, human loss, death and morbidity and sorrow caused by the financially bribery corrupted Australian psychiatry racket.

It's anathema to civil decency and civil society for the productivity commission to recommend any additional psychiatric and – psychiatric and psychiatric nursing to be increased as it has. These profoundly destructive forces are causing pandemic scale death and morbidity with

psychotropic neurotoxins. Now these are the things I think we should have. There's only four or five points.

I think the productivity commission must reveal the incidence of unsupported danger claims, as I said, it's unpredictable, you cannot do it. So if you examine how many times this is failing and you show it to be fraudulent and destructive and killing people, you're doing a great service to the community. You must reveal the coroners omitting neurotoxin deaths in causes of death. You must research neurotoxins deaths and the real statistics, in other words, not jumping out of a building or being hit by a car if it's a suicide. You must show the related connection to the psychotropic drugs.

You must rescind more psychiatric nurses – recommendation you made, because it's only going to make things worse. Now you must research the 115 per cent of Victoria versus New South Wales fraud of forced orders in Victoria to New South Wales.

MS ABRAMSON: I'm sure you've brought that to the attention of the Royal Commission.

MR FLOYD: Yes, but I'm saying you must – these are my points, I think you must research these things. Due to mass deaths, research recommended to criminal psychiatric praxis legislation. In other words, if some of these things are shown to be pure fraud and lies, I think you should be very active in going to the root of these and making some contribution to productivity in Australia.

MS ABRAMSON: Mr Floyd, thank you for bringing your presentation to us today. I will read what you put in to us. Harvey, did you have any questions?

PROF WHITEFORD: No.

MS ABRAMSON: No, thank you.

MR FLOYD: Thank you.

MS ABRAMSON: Thank you very much. Could I now ask if there's anybody who would like to give evidence today who's not on our list? We're happy – we've got a little bit of time to hear from you, so is there anyone who would like to speak? No, in that case, can I thank you all for your presence today. We've had a bit of trying technology, so thank you for persevering. Can I now adjourn the commission's hearings until Adelaide next year, and can I thank the commission staff for their hard work today, thank you.

MATTER ADJOURNED