



**Australian Government**  
**Productivity Commission**

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**PRODUCTIVITY COMMISSION**

**PUBLIC HEARING INTO MENTAL HEALTH**

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

**TRANSCRIPT OF PROCEEDINGS**

**AT LEVEL 12, 530 COLLINS STREET, MELBOURNE**  
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## INDEX

	<u>Page</u>
<b>PEOPLE POWER INTERNATIONAL</b> DR SURESH MARCANDAN	<b>129-133</b>
<b>MENTAL HEALTH VICTORIA</b> MR ANGUS CLELLAND	<b>133-139</b>
<b>BEYOND BLUE</b> MR SAM ROSEVEAR MR JASON DAVIES-KILDEA	<b>140-150</b>
<b>PREVENTION UNITED</b> DR STEPHEN CARBONE	<b>151-155</b>
<b>MR VIKEIN MOURADIAN</b>	<b>155-162</b>
<b>VICTORIAN MENTAL ILLNESS AWARENESS COUNCIL</b> MS MAGGIE TOKO	<b>162-166</b>
<b>MENTAL HEALTH LEGAL CENTRE</b> MS CHARLOTTE JONES	<b>166-173</b>
<b>CYBERVALUES.ORG</b> DR JOHN BELLAVANCE	<b>173-178</b>
<b>AUSTRALIA MUSIC THERAPY ASSOCIATION</b> MS BRIDGIT HOGAN DR JENNIFER BIBB	<b>179-185</b>
<b>MS DEBRA SCOTT</b>	<b>185-188</b>
<b>ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS, VICTORIA</b> DR ASTHA TOMAR	<b>189-196</b>

<b>AUSTRALIANS FOR MENTAL HEALTH</b> MR STEVE MICHELSON	<b>196-202</b>
<b>INDEPENDENT PRIVATE PSYCHIATRISTS GROUP</b> DR BILL PRING	<b>202-207</b>
<b>THE ACT OF LIVING</b> MR JULIAN McNALLY	<b>207-215</b>
<b>MS PRUE LYNCH</b>	<b>215-220</b>

**PROF KING:** Good morning. We'll recommence the public hearings into the release of our draft report on the Productivity Commission's inquiry into improving mental health in Australia. Again, just to introduce myself, I am Stephen King. My fellow Commissioners on this inquiry, Julie Abramson and Harvey Whiteford.

I'll just summarise the opening statement because we don't need to make the full opening statement again. These are a continuation of yesterday's hearings. Before beginning today's proceedings I would like to acknowledge the Wurundjeri people who are the traditional custodians of this land on which we are meeting, and pay respects to the Elders of the Kulin nation, past, present and emerging. I extend this respect to all Aboriginal and Torres Strait Islander peoples in attendance today.

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

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

Participants and those who have registered their interest in the inquiry will automatically be advised of the final reports released by government, which may be up to 25 parliamentary sitting days after completion. We like to conduct all hearings in a reasonably informal manner but I would like to remind participants that there are clear structures in our legislation for how these hearings are legally backed and a full transcript will be 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. And, again, just a reminder, the microphones are for the transcript. They don't amplify your voice.

These proceedings are live streamed. You can wave to YouTube. These proceedings are live streamed on the Commission's YouTube site. Would be interesting actually to go and have a look at the YouTube analytics and see how many we've got. Sorry, that's not in the opening statement. All participants who have registered to be here at this hearing have confirmed their understanding that they may be visible or audible online. If anyone here has queries about this or does not wish to be visible or audible online please approach one of our inquiry team members here today or feel free to leave the hearing now.

Participants are not required to take an oath but should be truthful in their remarks. Participants are welcome to comment on issues raised in other submissions. I also ask participants to ensure that their remarks are not defamatory on 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 and use the visitors' rooms next to the disabled toilets. Bronwyn will be here, so if at any time you are feeling distressed please approach one of our

staff who will assist. We will also have with us Bronwyn Williams who will be available to provide psychological support.

In the unlikely event of an emergency requiring evacuation of the building, the exits are located directly in the hallway that you would have come through between here and the lift. Upon hearing the evacuation tone please leave the building and assemble at the grassed area on Bligh Street. Unless given an alternative assembly point by the fire wardens your assembly point is Enterprise Park. If you require assistance please speak to one of our inquiry team members here today.

And our first participant today is Dr Suresh Marcandan. Please come up. And if for the transcript you would be able to state your name and your affiliation and then make any opening comments.

**DR MARCANDAN:** Good morning and thanks for the opportunity to present at this hearing. My name is Suresh Marcandan. I'm the managing partner of People Power International, a management consulting firm in Melbourne.

I returned to live in Melbourne after 25 years in Asia, in six countries in Asia, and therefore one of my objectives today is to draw on the experiences and learnings from those countries. I'm neither a medical practitioner nor a mental health expert. I'm a social entrepreneur with a deep interest and passion for alleviating human suffering in mental health preferably through education.

I must hasten to add that because of time restrictions I have not had the opportunity to go through the entire report but I have gone through the summary report and my observations are based on that. I must also emphasise that I am a great advocate of the systems thinking school of thought and most of my observations are based on a systems thinking approach and holistic approach to problem solving.

In my consulting business as well as in my community service activities I focus a great deal on complex and pluralistic social problems and challenges to which we deliver total solutions in a more holistic manner and from a systems thinking perspective. We believe that for these kinds of problems which are very complex direct intervention is not as preferred as an oblique intervention, what we call a flank attack, which alleviates the very stress, yesterday we heard comments on intimidatory effect of counselling and other mental health responses. We also heard about the stigma attached to it, so one of the suggestions I'm coming up with is a rather oblique intervention to this whole issue. I also see this as a huge national issue which should be tackled at the apex level, at a national level, and therefore we look at a very long-term solution rather than tinkering at the edges.

So the suggestions that I'm making is also very heavily centred on my learnings from Asia in a very oriental perspective to this problem particularly with examples drawn from India and Malaysia and Singapore and Bali where I've spent a lot of time in the last years.

The solutions are aimed at removing stigma, creating a lot of communication and community spirit and especially among the various stakeholders involved in the mental health issues, and therefore what I am suggesting albeit rather out of the box thinking, is that it is time to start

looking at yoga as a means of alleviating mental health issues. I have done a little summary paper on this for the three of you, and I'll be happy to answer any questions.

**PROF KING:** Would you like this to be a formal submission?

**DR MARCANDAN:** This is a preliminary submission. I'll be happy to present a formal submission if you feel it is necessary and I'd be happy to answer - - -

**PROF KING:** It's more for a publication so it can be put up as a submission that can go on the website.

**DR MARCANDAN:** Sure, that's no problem.

**PROF KING:** There's not a submission that doesn't go on the website.

**DR MARCANDAN:** Right. No, that's fine. Basically what I am saying is that contrary to popular myth yoga is not a religious ritual. Through the combination of various breathing techniques and postures it is a tried and tested tool for achieving perfect alignment, absolute harmony, and complete synchrony with that existence. My take on this is that mental health issues stem from a lack of control of body and mind and energies within you, therefore the challenge is to ensure that you have your personal mastery and confidence which will alleviate - or enhance your self-esteem. Quite often a lack of self-esteem, low morale, et cetera are caused by social or economic problems and this is an excellent way if it's fun it targets the very large base, so you can administer this to a wide range of people. It can include care givers, health care professionals, so for instance one of the examples I've quoted is that the Prime Minister of India has now made it mandatory for it to be embedded in the school curriculum so that even at that early stage they're able to take control of their mind, and therefore it has although I do not have immediate data to substantiate the outcomes, I'm aware that social ills and various other issues have reduced dramatically after the introduction of that. It is being tested in Sri Lanka, Malaysia and others and it's also in Bali. It is very widespread. I'll be happy to answer any questions.

**PROF KING:** Yes, Dr Marcandan, so in some ways I'm wondering whether what you're saying is really that novel. So cognitive behavioural therapy, which is if you like the standard approach for mild anxiety and depression, my understanding is that it's connection with what would - perhaps if you were coming from an Indian background would be considered as a yoga type practice, so issues such as diaphragmatic breathing, what is called mindfulness, which is very close to a meditative - would be viewed in an Indian context as meditation, but in a sense they're all - a number of those are already embedded in what we would call therapy, so I'm wondering is it really that you're saying we need more of that or is it that we're already moving in that direction?

**DR MARCANDAN:** I think there are similarities but a lot of differences too. Cognitive therapy, et cetera, one-on-one more clinical approaches, these are more community based attack the core of the problem and therefore less intimidatory and involve more participants, so they can, you know, be spread to a very wide audience and include all different stakeholders, so it's far less intimidatory, and therefore I do not think they're one and the same.

**PROF KING:** Okay.

**DR MARCANDAN:** Cognitive therapy is more threatening and direct. Yoga is an oblique intervention which not only tackles mental issues but general wellbeing and good health and spiritual, body, mind, energies, emotions.

**PROF KING:** I mean, on the other side we know that physical activity is directly connected. Exercise is directly connected with mental health, so, I mean, again is - coming at it from the other direction is really - is it yoga as such that would be beneficial or is it physical activity, involvement in community, so someone who attends a yoga class or group session with yoga is obviously gaining both the exercise benefits and the community involvement benefits. Someone who goes jogging with a group on Saturday morning or a community run they're gaining the same thing, so is there a difference there?

**DR MARCANDAN:** The primary outcome of yoga is not physical exercise. It is mental control. Quite often it is made to sound very (indistinct) or a new-aged gym workout for instance. It's not the case. The primary object here for yoga is to focus, train your mind and have control over yourself and also align mind, body, emotion and energy. It doesn't need to be physically demanding, but it is very focused on what it has to achieve and the outcomes decide.

**PROF KING:** Okay.

**MS ABRAMSON:** Excuse me - - -

**DR MARCANDAN:** So the comparison with physical workout is - - -

**MS ABRAMSON:** Excuse me one moment. I'm sorry to interrupt you. We've got some problem I think with the live stream. We've had people saying they can't - is that - okay, I'm sorry to have interrupted you.

**DR MARCANDAN:** That's all right.

**MS ABRAMSON:** Thanks.

**PROF KING:** Okay. Harvey and Julie, questions, comments?

**MS ABRAMSON:** I just wanted to ask, and I'm sorry I interrupted you, we've got a proposal in our report about a wellbeing teacher in schools, and I think some of the schools actually do have some mindfulness type training. I'm pretty confident that that's the case. So you're really proposing that the mindfulness that comes from yoga or the benefits of the yoga would be part of something that you might do in schools, and I think you said, is it India that's already - - -

**DR MARCANDAN:** It is. The current prime minister is pushing very hard for that.

**MS ABRAMSON:** Do you know if there have been any evaluations of it?

**DR MARCANDAN:** I'm not - I don't have access to any data admittedly but I'd be happy to look at it.

**MS ABRAMSON:** It would very interesting.

**DR MARCANDAN:** I'm not from India. I'm from - - -

**MS ABRAMSON:** No, no, I appreciate that.

**PROF KING:** No.

**DR MARCANDAN:** And neither am I an expert in yoga.

**MS ABRAMSON:** No, no, it's just that you cited - - -

**DR MARCANDAN:** It' s just that I love the concept.

**PROF KING:** Yes.

**MS ABRAMSON:** You cited it.

**PROF KING:** And cited the - - -

**MS ABRAMSON:** Well, we would be very interested if there's been any evaluations done of any of the outcomes. Thank you.

**DR MARCANDAN:** Yes. Well, the point that I'm trying to make is that it has to be systematically embedded.

**MS ABRAMSON:** No, I understand .

**DR MARCANDAN:** At all levels. It's not an ad hoc solution. It is a solution that has very long-term implications for mind, body and soul, and therefore it's something that has to be looked at very deeply.

**PROF KING:** Yes.

**MS ABRAMSON:** No, no, that - - -

**PROF KING:** But, again, to make recommendations to government we do need the evidence to show that having yoga imbedded in the system has led to an improvement in mental health.

**DR MARCANDAN:** Sure.

**PROF KING:** Yes. Okay.



**MS ABRAMSON:** Thank you for that.

**DR MARCANDAN:** Thank you.

**PROF KING:** Where are we? The next person we have this morning is Angus. Come on down. Mr Clelland, if you can state your name and your affiliation for the transcript and then any opening comment.

**MR CLELLAND:** Sure. Thank you. My name is Angus Clelland, I'm the chief executive officer of Mental Health Victoria. Now, Mental Health Victoria or MHV is the peak body for organisations that work within or intercept with the mental health sector here in Victoria.

Our aim as an organisation is simply to ensure that people living with mental illness get the treatment and support they need, when and where they need it. This means giving consumers the suite of services that they can choose from, be that delivered in the home, the community or in the hospital setting.

Our broad vision is for a system where people with lived experience, families and carers, are deeply involved in decision making, a system that's easy to navigate, provides continuity of care, a system that's focused on outcomes and a system that's well-resourced to meet current and future needs, a system that wraps around a person and one that responds to whole life needs.

As an organisation our membership is very diverse. It covers community and hospital based services, peak bodies, medical associations and the medical colleges, unions, police and emergencies services, associations, local government housing, homelessness and other organisations, so we have a very broad membership and stakeholder base.

We welcome the PC's draft report and absolutely congratulate you on a job well done. It's a terrific draft report and it's given us an enormous amount of issues and ideas to think about over the coming months I should say. We believe that the work that you're doing will profoundly impact the lives of millions of Australian subject to implementation of course, but we should be optimistic that, you know, change is afoot, and we're seeing, from a national perspective, a perfect storm of reform here in Victoria. We're awaiting with bated breath the release of the interim report from the Royal Commission next Thursday, but of course we've got an aged care Royal Commission, a disability Royal Commission and the potential for a Royal Commission into Veterans and Suicide, so all of these things converging in 2020 make it a remarkable year.

Now, we're particularly impressed with your report's emphasis of governance, prevention, early intervention and social determinants including housing, justice and employment, and we do welcome the opportunity to provide a formal response and we will do so by 23 January as requested.

In the interim we'd like to provide you with a couple of papers that we've just given to the table. One is a joint submission to the Royal Commission here in Victoria, done as a partnership between the Victoria Healthcare Association and ourselves, and a vast number of other organisations, and really that's a whole of sector view on mental health reform in this

state. Of course it's contextualised for Victoria. But of course many of the issues within that document cover the issues that you're covering as well, and really it's a whole of life, a cradle to the grave approach to mental health that we're looking for.

In preparing our submission we'll work with the Victorian Mental Health Policy Network which is a group that we auspice which is 25 peak bodies from around the state that come together every couple of months to talk about policy issues and advocacy issues of course, and we'll provide you something by the 23rd even if that means an early return from Christmas.

Now, in responding to the report, we're still looking in great detail at any of the sections but today we just wanted to emphasise a small number of issues and these relate to older people, planning, workforce, regional autonomy and structural reform, the easy stuff. Now, we understand that the PC hasn't looked in great detail at some of the issues associated with older people, and that's understandable given that we have an aged care Royal Commission underway.

We've been, I guess, a little bit concerned that the Royal Commission itself hasn't specifically tackled mental health in residential aged care facilities or in aged care and we hope that later this year in December the hearings in Canberra, which are about the interface with the health system will cover those issues in great detail.

We have provided you with a copy of our submission to the Royal Commission which draws together a large number of stakeholders including the aged care sector as well. The reason I guess for our concern is that Australia has an aging population. There's at least 15 per cent of the population is over 65, which is to be frank, a bureaucratic and arbitrary dividing line between being an adult and being an older person. I'm not quite sure what that actually means being- if you're no longer an adult you're an older person, but it's the way it works.

The mental health care needs of older Australians are often overlooked and while stigma and stereotypes might tell us otherwise mental ill health is not a normal part of aging and we shouldn't accept that. Those aged 65 and over find it incredibly difficult to access services and be that within the home or indeed within residential aged care facilities. The barriers are particularly high.

We find that older people access the services at a much lower rate than the general population. They find navigating the system very difficult for themselves and of course for their family and carers. They have very high medication rates and we would - many of us would've seen reports about that in the press of course, and at the same time very low MBS services rates relative to the rest of the population.

Many people would be unaware that males aged 85 and over have the highest age specific suicide rate in Australia and it's often overlooked. Now, people within residential aged care facilities and aged care in general rely on aged car staff and unpaid family and friend carers to identify the need for mental health care. This of course has a significant impact on a carer's own health and wellbeing, and their own financial, vocational and educational security outcomes. Aged care staff themselves are absolutely not equipped to respond to the mental health needs of residents and they lack even the most basic mental health awareness training

in their qualifications. It's left to overpaid nursing staff, who are managing very high staff ratios, to take on this responsibility. We advocate for mandatory staff ratios and mandatory mental health training for all aged care workers and this should be embedded within their qualification frameworks.

So moving on from there onto planning, jumping around. We very much strongly support the recommendation 7 that calls on the states and territory governments to determine and deliver the numbers of mental health beds that would meet the needs of each region, as well as providing alternatives to emergency departments.

Picking up on the points of Professor Copolov yesterday we agree that we need more beds and that these should be deployed in a range of settings. We also agree that the investment and community based mental health services and in other areas like housing and employment should ease pressure on EDs. We can't have investment in one without the other.

We draw the PC's attention to the Victorian Royal Commission report, page 22, which details principles for, I guess, a new approach to community mental health care that we're advocating here in the state. Consumers should be able to choose from a range of services delivered online, in the home, and in community mental healthcare settings, and community services such as mental health centres that have been raised and are currently in pilot need to be highly visible and accessible and we see these as a really important aspect of, one, addressing a service need but also helping to reduce stigma and normalising seeking help within the community.

The question for us of course is that we need a strong focus on these sorts of services while we wait for the big ticket items that - like housing and hospital bed based services that take a long time to plan and deliver, and we expect this of course will take many years. The question is it then becomes how much do we invest and where that sweet spot is, and if the PC can provide some modelling in relation to how much to invest and where and what impact that would have on the emergency department presentations that would be very welcome.

Moving quickly to workforce we'd very much welcome the recommendations around the national mental health workforce strategy and the recommendations regarding psychiatrists, mental health nurses, peer workers, as well as training for GPs. These are all critically important. We would emphasise of course that the mental health workforce is much broader than that and of course we include social workers and occupational therapists, psychologists and many others who are critical parts of the system. We concur with the points raised by Robyn Hunter, the CEO of Mind Australia, yesterday, in relation to the community mental health sector workforce. We need to recognise that the workforce is a key risk to any reform. There simply aren't enough qualified and experienced people available or willing to specialise in mental health, and part of the challenge for us all is to make mental health a desirable profession.

Moving quickly to planning, we very support much local tailoring of services to best meet the needs of consumers, but we are a little bit concerned about the recommendation around PHNs being able to redirect funding as they see fit. I'm referring to 24.2. Within the state here in Vitoria we've got at least 22 commissioning bodies if you include the PHNs plus the area health services, and by example if we look at psycho-social support services that creates

enormous variation from region or sub-region to sub-region throughout the state. We would like to see a fully resourced suite of national core services tailored to local conditions that are available to all consumers. That includes things like Headspace and psycho-social rehabilitation services.

Finally, moving to governance, we absolutely agree that structural reform is necessary and support recommendation 23.3 that governments should work together to perform the architecture of Australia's mental health system to clarify roles and responsibilities and incentivise governments to invest in those services that best meet the needs of people with mental illness and their carers.

The pooling of funds through a single body is at first glance a very attractive option for us and as I mentioned with those commissioning, so many different players commissioning, or should I say tendering, services across the state, the efficiencies associated with pooling and the approach of taking a whole population approach would be very useful for us. Within our Royal Commission submission we've called on the establishment of an independent Mental Health and Wellbeing Commission for the state. Victoria lacks a Mental Health Commission. And the scope would be to span the whole of population mental health and addiction and provide independent monitoring and oversight of the entire system. Part of the challenge that we have faced here in Victoria is that there's no single body overseeing the entire population and all parts of the system, and that's a great challenge for us.

So just in conclusion, on behalf of Mental Health Victoria and its stakeholders we'd like to thank the PC for producing such a comprehensive and thought provoking draft report. We very much look forward to providing a more detailed response by 23 January and look forward to the final report. Thank you very much.

**PROF KING:** Thank you, Angus. I'll start with a question relating to the regional autonomy of the service providers and then pass over to my colleagues. I guess where we've gone in our report is to say well, you need different services depending on the localities and we had examples yesterday of the differences between Coburg and Box Hill here in Melbourne.

**MR CLELLAND:** Indeed.

**PROF KING:** Rather than saying well, there is a specific set of base services, so I'd like to understand what you mean by tailored to local needs. That's the first question, but I'll put another one in. Our approach to which services has been they should only be evaluated services, so the aim that we get to in the five or 10 years is the NMHC is an evaluation body which has evaluated relevant programs - - -

**MR CLELLAND:** Sure.

**PROF KING:** And the local commissioning authorities then say, well, we haven't got carte blanche. We have to choose between those programs that have been shown to be effective but we need to choose for our local community. So I'd like to get your feedback on, you know, where you see the weaknesses or strengths in that and when you say, "tailored to local conditions", that I must confess - I'd like to understand what you're getting at, and you might want to use Headspace as an example, but given that you're not - - -

**MR CLELLAND:** Talking for Headspace.

**PROF KING:** Yes, I'm more than happy for you not to do that, but I would like to get a better view of what you mean by that.

**MR CLELLAND:** I guess we're possibly using different language to describe some of the same things, but we'd see a suite of services like care coordination, for example, being a core service that's available to anyone that needs it. The way it would be delivered would vary depending on perhaps the location or indeed the group that you're talking about. So it might be done in a different way for CALD groups or LGBTIQ groups, but at its base it's a care coordination service, and absolutely all of these things have to be evaluated and, you know, shown to provide the benefits that we're after. It's that focus on that outcome rather than the input side of things. So we would like to be able to say to anyone within Victoria, indeed nationally, that regardless of where you are you would be able to access care coordination, and it might be services in the home, it might be sort of youth related early psychosis support and so on. The way that that gets delivered locally would vary of course, but at its core it's a set of services that everyone can access. Does that make sense?

**PROF KING:** Yes. And I will push you a little bit further on that because you did mention in your comments Headspace, and Headspace is currently - PHNs are directed to fund Headspace centres and we've said, well, that sort of direction we don't consider consistent with a model of regional commissioning for local needs, but I assume you disagree with our position on that, so - - -

**MR CLELLAND:** Yes, look, the - it's all about, I guess, giving that right balance, and as a state we see extraordinary variation across regions in terms of what's delivered, and that particular model providing so much autonomy over decision making I think is counter-productive and getting the balance right I think is what we need to approach. I don't - - -

**PROF KING:** You need a simple direction then.

**MR CLELLAND:** Yes, and we've played around with terms like with consistent set of services but, you know, with local variation, those sort of things. But I think this is going to be one of the big challenges for the government's reform getting that balance right.

**PROF KING:** Okay. Thank you.

**MS ABRAMSON:** Mr Clelland, thank you very much for presenting your evidence in such a clear and concise way. That's been really, really helpful.

**MR CLELLAND:** Thank you.

**MS ABRAMSON:** I wanted to ask you two questions.

**MR CLELLAND:** Sure.

**MS ABRAMSON:** The first one is you made a very helpful comment about what you saw

as national core services, and one of the things that we thought a lot of in the report is who does what, Commonwealth or State, and there are some programs where the delivery of suicide prevention strategies we thought there was a role for national - rollout in national government. Very interested in understanding what you think might come under a banner of national core services.

**MR CLELLAND:** That's a terrific question.

**MS ABRAMSON:** Happy to take on notice. Yes.

**MR CLELLAND:** We'll take that on notice, and this is a subject of great debate amongst the stakeholder groups, but we will take that on notice and provide back an opinion on that.

**MS ABRAMSON:** That would be very helpful. Just - - -

**MR CLELLAND:** I guess - sorry, just to add to that, so long as they're funded and they're done well we're not concerned, I guess, but we'll do some work on that.

**MS ABRAMSON:** Yes, I suppose we're - thank you for that - where we're coming from is that we think, well, what makes sense to deliver one type of program across the whole of Australia and - - -

**MR CLELLAND:** Yes.

**MS ABRAMSON:** - - -that's in suicide prevention. We thought that that was valid, but there may be other services as well. The other thing was you made some interesting comments about the Victorian - about Mental Health Commissions, and in our draft report we concentrated on the National Mental Commission because we did see that each of the states had slightly different models. So I'm just interested in you expanding a bit on what you said about the Victorian situation.

**MR CLELLAND:** Yes, I guess we've come to this I guess before and produced, you know, our submission back in July in relation to the Royal Commission. One of the key gaps from a government's perspective within a state from our perspective is lack of an oversight body that can monitor, report independently to Parliament, act as watch dog, and to be frank, to snap at the heels of government when need be to make sure that what reforms are agreed are delivered and done particularly well.

We are quite interested in the model that's being developed within New Zealand which brings together the concept of wellbeing but also alcohol and other drugs to bring together those two streams that are approached as very separate silos, at least here in Victoria.

From a national perspective if we go down the path of a beefed up National Mental Health Commission, and I guess the question for us is, is there necessarily that need at a state level for such a body, and it would be ideal if we had one national body that could oversee the entire population and provide, you know, the right direction and so on that's been identified within your reports. So it's a really fascinating question, so - - -

**MS ABRAMSON:** We'd welcome your comments on that. I suppose two further things I'd ask you, evaluation of programs, that's something that we've seen as something the revamped National Mental Health Commission could do, so when you're thinking about the State Commission you might want to turn your mind to that and also it's very interesting what you said about New Zealand so we'd welcome some more information on that.

**MR CLELLAND:** Sure, we'll take it on notice. Thank you.

**MS ABRAMSON:** Thank you very much.

**PROF KING:** So I think the questions have been asked really. So just clarifying the support from your position in Victoria is that mental Health and addiction services are delivered together as part of a single suite of broader mental health services and not separate?

**MR CLELLAND:** That's right. Yes.

**PROF KING:** So when it comes to, I guess, population level substance use services more broadly, is that part of that suite of services if you understand what I'm asking there?

**MR CLELLAND:** Could you elaborate just a little?

**PROF KING:** So where we're talking about where alcohol is sold across Australia for example issues about, you know, national use of - certain substance uses and their restrictions legally varies from state to state so in a national approach thinking through how that would play out at a local level where we're talking about, you know, a regional commissioned authority or - the balance between whether it's just the clinical services or the psycho-social supports for the location population versus the bigger picture which often surround alcohol and other drugs.

**MR CLELLAND:** I guess there's a role there at a local level and at a national level. I'm sort of thinking through this as we speak. In terms of service delivery on the ground for the consumer for families and so on, absolutely there should be an integrated suite of services that can be accessed. In terms of policy making at a national level I'd expect that such Commission would be heavily involved in it, but I don't really have a view about where the actual policy making occurs, but it's something that we can have a look at.

**PROF KING:** Thank you. That's all then. Thank you very much.

**MR CLELLAND:** Great. Thank you very much.

**MS ABRAMSON:** Thank you very much.

**MR CLELLAND:** Cheers.

**PROF KING:** And next we have Mr Rosevear and Mr Davies-Kildea from Beyond Blue. And if you would identify yourselves and your organisation, despite the fact that I just did that.

**MR DAVIES-KILDEA:** Sure.

**PROF KING:** For the transcript and then if you've got any opening comments you'd like to make.

**MR ROSEVEAR:** No problem. So, I'm Sam Rosevear, the general manager of strategy and policy, Beyond Blue.

**MR DAVIES-KILDEA:** And I'm Jason Davies-Kildea. I'm head of policy and advocacy at Beyond Blue.

**MR ROSEVEAR:** So we've got four core messages for you today and the first is just a hearty congratulations from Beyond Blue on what is a really strong and comprehensive report that would undoubtedly lift the mental health of Australians right across the country. We think this is fantastic, and we'd highlight your emphasis on the early years, the emphasis on low intensity support, recommendations for universal aftercare involving consumers and carers in all aspects of the development of mental health policy and design and evaluation, building the peer workforce, a national stigma reduction strategy, strengthening the role of the National Mental Health Commission, and I could go on and on. A fantastic report. Thank you, from the bottom of our hearts.

But today of course is about how can we make the report even stronger and so we're going to try to give you some actionable clear recommendations that we would suggest, and there are three areas. The first is an even stronger focus on prevention, and no doubt you're thinking, "Didn't we throw the kitchen sink at that?", but we think you can go even further. A second is a bolder program of structural reform to underpin the low intensity sector, and the final one is putting a bit more prevention into suicide prevention.

So, firstly, just to prevention, we think if you're going to change the incidents of mental ill health in Australia that just as with physical health prevention is overwhelmingly the key. We live in a country where too many people are experiencing adverse childhood experiences which are responsible for 16 to 33 per cent of anxiety, depression and self-harm in adulthood, and we know that, as you rightly point out, 50 per cent of mental health conditions are arising before the age of 14 and 75 per cent before the age of 25, and partly as a result we've got half the country, or almost half the country experiencing mental health conditions in their adulthood.

So the holy grail of mental health is preventing that happening in the first place, and we've got three areas we think we can do more. The first is equipping parents who are the strongest influence on children's social and emotional wellbeing to raise thriving children. The second is equipping educators to create mentally healthy learning communities that support children. And the final one is equipping workplaces so that workers are placed where our 13,000,000 workers can thrive and contribute.

And to just talk a little bit more about each of those, firstly, we really acknowledge that the Commissioner has given great emphasis to the early years including universal screening and expanding parent education programs in child and family health centres. However, we think a signature initiative, perhaps the signature initiative of the report should be to recommend



that Australian and State Governments work together to build and systematically fund a comprehensive national system of support for children naught to 12 and their parents.

The reason for that is, as I describe, it is the biggest issue to change the trajectory of Australia's mental health. We know that a system barely exists to support parents to raise thriving children. The National Mental Health Commission in their landmark 2014 reform report stated:

*There remains a critical gap for children aged from birth to 12 years both for the child and for parents who need to be supported to maximising their child's development and wellbeing.*

So it's the biggest issue, and we don't have a system to do something about it. And we know one in seven kids aged four to 11 are having problems and less than half are getting help, and we know that parents often don't have the knowledge to support their mental health, and as a parent of a seven year-year-old I can say I could really value more advice and support to raise a thriving child at each stage of the transitions for kids. So we think there's no greater priority than this, and we can talk more in conversation about what that might look like.

Our second prevention idea is that we agree with the Commission wholeheartedly there are too many frameworks and too many programs in schools leading to confusion but we feel like the report stops short of them nailing the answer and we believe the answer is to recommend that COAG education ministers agree to the adoption of a single national framework to support wellbeing in schools and early learning services, and we believe that Be You is overwhelmingly the obvious choice for a number of reasons. Firstly, it was designed to create one clear evidence based framework by joining up a series of successful but disconnected programs including KidsMatter, MindMatters, Headspace, School Support and Responsibility. It's already being funded nationally and substantially. It is the clear choice of schools and early learning centres, so we know that having launched in November 2018 6300 schools have signed on, 67 per cent; 2900 early learning centres have signed on; 90,000 individuals have created learning accounts. We'd also pointed out that this is evidence based, so those programs that it was built on themselves were world leading. One quick quote, an evaluation of KidsMatter by Flinders University found it was:

*associated with statistically and practical or practically significant improvements in students' measured mental health reducing mental health difficulties and increasing mental health strengths.*

It also accords with the Lancet Global Commissioner's recommendations where they say the most effective universal, social and emotional learning interventions use a whole school approach in which the social and emotional learning and support is supported by a school ethos and a physical and social environment that is health enabling involving staff, students, parents and the local community. This is exactly what Be You does.

I could say more about this but I'll just land on one final point. Be You was developed with and has the very strong support of the key stakeholders including Commonwealth and State and Territory education departments, so we think it's very important. I better stop there.

**MR DAVIES-KILDEA:** I'm going to take up from there and really take up that theme, I guess, of how bringing together fragmented services programs, information in education is replicated in the workplace sector, and that's recognised well in the PC's interim report. I think there's a great contribution that's been made by the report in addressing the risks particularly around workplace mental health, and if there's any room for improvement it's more around the emphasis about the opportunities present, and I think that is a place where so many millions of Australians are. The opportunity for having mentally healthy workplaces as a probative proactive contribution to population of mental health I think could go a step further.

Certainly it's recognised that workplaces are seeking direction. They're looking for opportunity and there's a multitude of, you know, potential places of information here. What was missing, I guess, for us is recognition of the national mental health workplace initiative which was funded in this year's Federal budget, and it brings that opportunity to pull all of that together from a national level. It's led by the National Mental Health Commission and supported by the Mentally Healthy Workplace Alliance, so already it's got in place the foundational funding that will be required to bring some of this together, and it builds on an established collaboration of diverse interests from unions to, you know, employer bodies, government mental health as well. So I think there is a lot more that can be done in recognition of what's begun already and has momentum and in fact to potentially begin that again creates some other risks.

**MR ROSEVEAR:** So now to stronger structural reform to underpin the low intensity sector, so we thought it was great to see the Commission recognise stepped care and also the importance of low intensity and we love the estimate that 450,000 people currently being served through Better Access could be served through low intensity. We think that's an incredibly important finding. And we also like the fact that you recognise that low intensity support is the need for the vast bulk of the population and yet you have a service system that's very much in its infancy and is actually quite tiny.

So we think there's four elements of structural reform that it'd be worth giving further emphasis to. The first is the micro-economic foundations of the sector. So, for example, all sectors need good education and training pathways in workforce development. If you're trying to develop a program in low intensity services at the moment you have to drive those often from scratch. We need a comprehensive system of accreditation of services, so consumers can feel confident that they are drawing on evidence based interventions. Consumer awareness as the Commission has recognised is a real issue that we don't have a national culture of taking up low intensity services, so we need to inform consumers that this is something that can benefit them. And, finally, the linkages to the clinical system are obviously seminal important. If GPs think that the two options are medication and Better Access then they will continue to use those options and low intensity will struggle to find a foothold.

The second area for structural reform is meeting demand and need long term, so it was great to see a recommendation around 150,000 additional places, but the report says there's 450,000 people who would be better off, not Better Access but low intensity, and we also know 5.8 million Australians are at risk and 2.2 million Australians have mild mental health conditions, and 1.1 million Australians have moderate and 60 per cent of the population are

well and hoping to stay that well, and all of them would benefit from low intensity support. So what is the pathway and the mechanisms, the funding mechanisms and the governance that's going to lead to a low intensity support system to arise, and that needs to be addressed.

The third issue that we think is important is structural reform in low intensity is national funding. So if we're trying to from a situation where we have a radically under-funded too small system then regional commissioning, though absolutely seminal, and with a terrific place in the system, is not going to get the job done. We need to be able to nationally fund the expansion of services. So some of the great recommendations you've put in the report including 150,000 more places and universal aftercare. If that's going to come to pass the best way to do it is through national funding mechanisms. Requiring service providers to go across 31 different Commissioners is not an easy way to create national services. It makes it really difficult to get the economies at scale that reap the cost benefits that are the promise of low intensity.

Furthermore there is a serious institutional failure at the heart of mental health funding in our country and it's this, you've got basically demand driven funding for the clinical system, so we've identified that the funding for Medicare subsidised clinical mental health services they've gone from 351,000,000 in 2006/07 to \$1.2 billion, almost a quadrupling by 2017/2018. Meanwhile low intensity support is heavily capped and capped at a rate that will never allow a major system to emerge.

So what you have is a system where the minority of the population needing clinical support has demand driven funding which is going up in gangbusters whilst what most of the population needs is heavily, heavily capped at a rate that would never allow a system to emerge in anything like the scale that is needed. So this is an institutional failure that I think is right up the PC's alley in terms of the sorts of thing you're so effective at solving and we think you need to give that consideration.

Our fourth area and final area in relation to low intensity structure reform is expanding the full suite of evidence-based interventions that consumers want not simply clinician supported online to the. So we know that consumers want a mix of coaching through various modalities face to face, online and over the phone and international best practice in the Lancet Commission highlights that much of the value of low intensity services are not about being clinician supported and clinician run. If low intensity means clinician supported we are going to have got out an enormous cheque book because either taxpayers are going to pay or consumers are going to have to be asked to pay many of whom will be turned away by the price tag.

The big promise of low intensity are alternative workforces, peer to peer support, coaches providing help for people with mild to moderate depression and anxiety, support coordinators helping people with after care after people have tried to take their own lives, and wellbeing staff supporting children in schools are just some of the examples. Now, the important thing here is not that they're clinicians themselves but that they're clinically supervised and effectively trained and that there's evidence that the programs work.

Can I say I thought it as a bit un-PC like to say, 'Let's back this one modality'. (indistinct) more central planning in orientation than what I see the PC normally advocating which is

more about giving consumers a choice and developing a market of options, some which are relatively higher cost but provide more intensive support, others which are lower cost and in that way meeting the needs of the whole community.

And just finally, you did have an information request 5.1 in relation to CBT coaching and I'll only just make some preliminary remarks which are CBT coaching including innovate access to psychological therapies in the UK and NewAccess is a proven intervention which delivers powerful recovery rates and it is cost effect at scale. We're all in agreement it's effective so NewAccess delivering 70 per cent recovery rates is pretty remarkable and we were delighted to see the table on page 223 of the report which showed NewAccess delivering the highest benefit in terms of impact of all the interventions in that table noting that a number of them actually hadn't been evaluated.

So the issue now comes down to cost effectiveness and we'll provide, as we have previously, information showing the staff costs at scale are lower, the training costs are lower and of course the foregone costs to participation of being people out of the workforce for very long periods of time doing training are very much lower. Thank you for enduring that part of the low intensity but that was the one think we felt strongest about. We'll just talk about suicide prevention and then open it up.

**MR DAVIES-KILDEA:** So just very briefly. Look, we certainly very strongly welcome the recommendation about universal after care, I think it's a fabulous recommendation and much needed. I guess our hope is that we could push it ever further along the continuum of suicidality to provide more support to people long before they've made an attempt to take their own lives. So there are some elements in that which I think are really promising.

The alternatives to emergency departments for instance are really important. I think there could be more space potentially for those to exist, you know, beyond even the hospital grounds at the point at which we've already kind of, you know, medicalised the solution or provided that particular context, there could be further opportunities. Co-responder models building the peer workforce are all great kind of interactions.

And we certainly support, you know, the range of trials that are currently happening in terms of suicide preventions, systems (indistinct words) is excellent. Within that, how do we ensure that we continue to kind of push back along that spectrum to the earlier points where rather than, you know, within hospitals and clinical situations we can support people within the community and potentially even supporting people right back to their own homes where they're in a safe environment to do so.

We've looked at a range of things from the brief intervention that's being trialled in Scotland, for instance, which connects a range of gatekeeper roles and really those first points of contact with support at the back end, for people who are experiencing all forms of distress that might initially be identified by them or others as suicidal but can lead to that without the right kind of supports; we think those are the things right along the spectrum of safe space as to anyone who needs them with supports backed up whether that's for respite or whether that's to provide safety and need and to kind of get the collection of support around you to ensure that you're in the right space for recovery. I think that will do us to begin with but

really happy to answer any questions. We will be providing a detailed response as well in January.

**PROF KING:** All right, thank you. Again I'll kick off and then pass to my colleagues. You talked about, you know, equipping parents with a national system of support for children 0-12 and their parents and you suggested that, you know, practical ways to do this we could discuss that, was exactly my question.

**MR DAVIES-KILDEA:** Sure.

**PROF KING:** A great idea but what are the practical on the ground recommendations we need to make not (indistinct words) level but once you've said, 'Yes, we want a national strategy and the national strategy needs to make sure it does A, B, C, D'.

**MR ROSEVEAR:** Sure. This is a difficult question because we're trying to establish a system that doesn't, you know, considerably exist so it's a pioneering exercise but some of the issues that we highlight are: I think there's need for action on three levels. One is the universal primary prevention area; another is early intervention; and then the final piece, and we'll get to the brass tacks in a minute but just the framework, the final is support for families in tremendous need.

So, so many issues around universal primary prevention are really ensuring that parents are ready for the journey before children come along at that, you know, perinatal period because it is such a profound change and their mental health being strong and knowing how to support kids is very important so some of the practical issues including, 'How do you have online support and information for people that is quickly available and readily accessible' and the Raising Children Network is an example of something which I think is absolutely fantastic. I'm always prone to wanting to talk about healthy families at Beyond Blue but I won't, I'll take about Raising Children Network.

Raising Children Network, you go on to that site and you can see every life stage straight away so as a parent you can go - right, 0-3 or they're about to go to school or, you know, they're in school - and then there's a drop down menu of all the things that you need to do to support your child from, you know, health to mental health to diet to, you know, emerging into the school system and so on. Now, how do we create a culture where all Australian parents actively and proactively invest time to prepare themselves and have the knowledge to support their children? So online support is one really important and practical aspect of this and I commend the Raising Children Network but how can we make that part of the popular culture and publicise that much more strongly?

Another part of this could be drawing on the fact that in private practice there are parent coaches so if you're wealthy enough you can go and get yourself a parenting coach but this is a classic of the low intensity options that we have and that's, 'Could we draw on experienced parents and grandparents who want to give back and arm them with the evidence-based information of the Raising Children Network and have them available to young parents to help them with the raising of their kids?'

There's an enormous need, there's an incredible workforce and there's a lot of evidence, informed information, that can be passed on so there's a range of ways there in that universal prevention space that need to be identified and it's a hard piece of policy work because we're in pioneering territory so you won't have randomised control trials done on 100 countries that show unequivocally that this evidence works. Rather, you're going to need to establish a system that trials things, evaluates them, evolves them, closes them down when they don't work, beefs them up when they do work so that's going to need to be a learning system.

In the early intervention area: so we see, and we put in our previous submission, a number of individual examples of local programs which work that parents can go along to when kids are in trouble and get the support they need both for the mental health of the child but also in terms of how parents can be equipped to support kids with mental health conditions. But they're very small scale, they're very local and there's not coverage across the country so a big question that you'd want to put in there is, 'Australian and State Governments, how can we draw on the best of what exists and make it widely available so we don't have a world where one in seven kids aged 4-11 are in trouble and less than half are getting any support at all?'

And then finally, support for families in greatest need, you know, where significant adverse childhood experiences are prevalent. We know this is responsible for 16-33 per cent of depression, anxiety and self-harm in adults. This is an area too important to ignore and we know we have a system that tries hard and occasionally does well but could be a lot stronger. So they're some of the issues that could be teased out, some of those practical issues that could be teased out and drawn on. We don't think just saying family health services providing more parenting education is enough, there's so much more there that needs to be drawn out and considered and built up to get the comprehensive national system we need.

**MS ABRAMSON:** Thank you. I've got to questions I'd like to ask but I'd also like to thank you as an organisation for the very constructive and helpful way that you've engaged with the Commissioner so thank you and we look forward to of course that continuing. My first question is about Be You and it's really about the practical support that's available for schools implementing Be You which is of course an online program and I understand that, correct me if I've got this wrong, you have about 70 consultants helping school but there's 6000+ schools so I'm really interested in that type of support and then the second question related to that is also dealing with stigma and getting people to come forward so perhaps if you could deal with those two issues for me.

**MR ROSEVEAR:** Sure. So the 70 staff are available online and can be available on site and their primary task is to help schools develop mental health strategies which can include, you know, the empowering of the educators through the online material that is available to support the development of teachers so that they can help to raise or help students to thrive to create links to local service providers so an important point about Be You is not the suggestion that it will solve all mental health problems in schools but what it will do mostly is empower and educate teachers to raise thriving kids and it will also enable the development of strategies in schools that bring together parents, teachers and students to underpin the wellbeing of kids.

Now, in terms of downstream support that is not something that Be You does in terms of providing mental health specialised clinical support, that's a separate issue. Am I answering your question?

**MS ABRAMSON:** Yes, no it's absolutely fine. It was more the resourcing because we're looking at this, 'Where would be putting the funding and the support?' so we've got the proposal about the wellbeing leader in schools, you could draw on the Be You material but we were just drawing the contrast between the amount of people that you might need to support that program being fully implemented or used across schools, that was all.

**MR ROSEVEAR:** I think the distinction is that Be You provides the overarching framework for mentally healthy educational communities at what level under which arrange programs will sit. Those programs themselves will absolutely need to be resourced very differently to Be You in the way that it functions.

**MS ABRAMSON:** No, no I understand. And then the second point was: you will have seen I'm sure when we put what we thought was a modest proposal about screening to assist parents in recognising issues with very young children, emotional and social wellbeing, that we got, you know, some of the criticism around that and that's really about stigma so really interested on your views on that.

**MR DAVIES-KILDEA:** I reckon the key to screening is around the how it's done. It's what the screening is looking for, how it's conducted - you know, even where it's conducted and who by. So, yes, we're very aware that there is a natural reaction by parents and concerned community members around, you know, the potential stigmatisation, medicalisation, you know, of diagnosing very young children and we would share many of those concerns ourselves, that's not the intent of a screening. But I think there can be some work done and this will certainly be part of our submission around how that screening itself is framed, how it's conducted, to reduce the stigma associated with it.

And I think the other part of it is that the screening itself desperately needs to be connected to appropriate levels of support so if something is identified by a screening then parents, children, carers, everybody has access to ensure that they've got the follow-up they need to ensure that things are on track.

**MS ABRAMSON:** Thank you. The final question - I'm sorry, Harvey, I've just got one more question. It was really interesting to hear you talk about the low intensity issues so we're quite interested in the workforce: how would you fund that and if you were to fund it from, just in a hypothetical sense, from taxpayer funding; what type of accreditation would you have around that workforce?

**MR DAVIES-KILDEA:** Look, we're really supportive of the notion of an accreditation scheme and in fact that's something that we've been pursuing and asking questions around what that would look like.

**MS ABRAMSON:** Is that for peer workers or more broadly?

**MR DAVIES-KILDEA:** It would include peer workers but not necessarily, you know, be constrained only to peer workers. The way that NewAccess has been rolled out across the country certainly include a range of people, you know, who fit into that peer worker category but go beyond that as well and, you know, we've absolutely seen strengths in that. There's no doubt that, you know, being clear around the skill base, the methods that are used in low intensity CBT, the evidence base behind that to give the clinicians who refer people into those courses of treatment, you know, really have the confidence needed because, you know, it very much is related to scale and ensuring that that very large group of people with mild conditions don't progress further down the track means you've got to be able to effectively intervene.

I don't think we have all the answers to the kind of accreditation yet, part of it may relate to peer workforce but as I say it can't be constrained to that but we'll certainly look forward to kind of engaging in further in what that might look like and collaborating in terms of how that might roll out across the country.

**MS ABRAMSON:** Thank you, and I'll get you to take on - I notice, Michael, that my colleague will have some questions - the barriers at the moment which are preventing taking up that low intensity model, thank you?

**PROF WHITEFORD:** Thank you, so one question again about CBT coaching. So you can see from our information request that we were looking for more information. I think one of the key phrases you had was 'at scale'.

**MR DAVIES-KILDEA:** Yes.

**PROF WHITEFORD:** So the cost effectiveness at scale, can you just talk a little about how that might demonstrate a different outcome to what we've got now as far as the cost effectiveness of the roll out of the program for all CBT coaches?

**MR ROSEVEAR:** Yes. I think whenever you have a pioneering service, and there are many examples when it starts up the scale is low and the fixed costs are high so at a certain point you're always going to say, 'Oh that doesn't look right' but that's not the question that we should be asking. The question we should be asking is, 'If this was a seminal part of our low intensity system, 20 times more people in the UK get access to IAPT than get access to NewAccess and with 560,000 people in the UK getting that access it's heavily more cost effective so we don't think it's fair to say at a really early point in the process as you're trying to develop this system with low scale the costs look a bit high, done and dusted, CBT doesn't work. As you've identified it gets fantastic results so 70 per cent recovery rate is fantastic. We'll give you some information and some analysis that shows that if you could get it to a large scale, which has been done in the UK and can be done here, that the costs are pretty useful.

**PROF WHITEFORD:** So just push you a little bit hard on it. So one of the challenges in the IACT is the term - - -

**MR ROSEVEAR:** Sorry, the term of the trainers.



**PROF WHITEFORD:** That's right and the people who are the providers. If they move on from IACT or CBT Coaching Australia to other roles and we have to constantly retrain them; is that going to be a limiting step or how is that being tackled in the IACT program in the UK that you're referring to so when you got to scale that term of the trainers does it become less or how do we handle that?

**MR ROSEVEAR:** Well, if you're talking about the costs of training, the costs of NewAccess training is about \$17,000, the cost of training a psychologist is \$25,000-\$30,000 a year for four to eight years so if we're comparing like with like we're happy to have the conversation about training costs.

**MR DAVIES-KILDEA:** But in terms of the workforce I think it's really, you know, unclear at this point because we haven't reached anything near scale, people who move on from that workforce are about what are the connections to other workforces and how is their satisfaction in their current role, you know, actually working out?' I'm not sure necessarily that the NHS in the UK and where we are in Australia gives us the exact comparisons we need to say, 'What's happening over there?', you know, (indistinct words) yet? Maybe it is but we actually won't, you know, be really clear in terms of our ability to assess that until we've got much closer to the scale and how the low intensity system fit in with the other parts of the mental health system.

**MR ROSEVEAR:** But I'm hearing your issue is, is there too much turnover in CBT coaching? Is that - - -

**PROF WHITEFORD:** Well, that's one of the issue in relation to that so we've got to - there's no doubt that it's got a place from what we've heard, the question is, 'Can we grow it to the scale that we think it might have?' - I mean, if we do, how do we have the workforce to support that because the cost of replacing that workforce continually, if that's the issue, might add to the cost of the program.

**MR ROSEVEAR:** Yes, so your two big issues are around the turnover and around the ability to move it to the scale that you would then get the cost efficiencies?

**MR DAVIES-KILDEA:** That's something we can have a look in - you know, within our own context in trying to work with our partners in delivering this to understand better is our experience in Australia so far comparable to the UK although again it's still and experience that at the moment is at a relatively small scale.

**PROF KING:** Can I follow up on exactly that same question because you pointed out quite correctly that it's unusual for the Productivity Commission to say, 'Ah, well this is modality for low intensity services' but at the same time you've mentioned the importance of scale. If you had five or seven (indistinct words) national programs and the problem is if only one/two or maybe even three would possibly reach scale then you may be by saying, 'Let's start off with (indistinct words)' you may in fact (indistinct words) none of them to be able to reach scale so at some stage if you were having a national program the national delivers in charge of that has to say, 'Right, well the evidence says these are the one, two or three best programs (indistinct words), we'll see how consumers choose, we'll see which of those gets to scale and maybe we'll end up with two in five years' time but - - -

**MR ROSEVEAR:** We were convinced by the Commission's own analysis which said, 'Consumers or people want choice' Some people want on the phone, some people want face to face and some people want online. So if that's your analysis and we've got programs that can fill those options, then I would have thought recommending expansion across a small suite of programs that meet the needs of consumers in those three areas would be the way to go rather than just having the one method and of course you can go out and find out what is evidence-based and have people demonstrate cost effectiveness and ability to scale and all of those sorts of things can be built into program design.

**MR DAVIES-KILDEA:** I'd say also that, you know, we certainly don't have a problem with clinicians (indistinct) online treatment. I absolutely agree that at the low intensity end that has to be a major part and, you know, 150,000 people going into that kind of treatment seems to me to be entirely appropriate. The question is, 'What about everybody else?' and your report has quite rightly pointed out some of the limitations of online. You know, 2.5 million Australians without access to the internet still, you know, people who have technological illiteracy issues and there are other kind of (indistinct words).

There are a whole range of constraints where people cannot actually, regardless of the choice factor which should be there anyway, get the benefits that they would want and they need from online therapy so it's not a matter of, you know, the gap between 1 and 7 necessarily but we just want to kind of expand it more clearly in the share of need which, you know, it's certainly recognised that it's at least warranted in 50,000 Australian.

**MR ROSEVEAR:** And if the volume is so high that you envisage expanding at least 450,000 let alone the 2.2 million people with mild conditions, that doesn't seem like a one modality solution, it seems like a range of choice would be pretty fruitful for the Australian community.

**PROF KING:** Thank you.

**MR ROSEVEAR:** Thank you.

**MS ABRAMSON:** Thanks very much.

**PROF KING:** We might duck out for a toilet break.

**MS ABRAMSON:** That would be great.

**PROF KING:** We are going to duck out for a two minute toilet break.

## **SHORT ADJOURNMENT**

**PROF KING:** The next person is Stephen Carbone. If you could state your name, position or organisation for the transcript and then if you have any opening comments and again just remind people the microphones are purely for transcript not for amplification.

**DR CARBONE:** My name is Dr Stephen Carbone. I'm the executive director of Prevention United. Okay, so thank you very much first of all for giving me the opportunity to address this hearing. As I said my name is Stephen Carbone, I'm the executive director of Prevention United. I have over 30 years' experience working in the health and mental health field both as a clinician and as a public health professional and also have supported many families members who have experienced mental ill health.

Prevention United is a relatively new mental health promotion charity that focuses on the primary prevention of mental health conditions. My colleagues and I founded Prevention United because we believed there was a major gap in Australia's approach the primary prevention of mental health conditions of mental disorders/mental illness as some people call them and by that I mean preventing conditions like depression and anxiety disorders and others before they start.

Our organisation focuses on three main areas: awareness and advocacy; providing prevention information resources for the public; and capacity building for organisations wanting to increase their focus on the promotion of mental wellbeing or the prevention of mental health conditions. We'd like to congratulate you on your comprehensive reviews. We particularly welcome the Commission's recognition of the importance of prevention in the mental health field.

Mental health conditions are not inevitable and many conditions such as depression can be prevented from occurring in the first place. That doesn't mean we can prevent every case of depression from occurring just like we can't prevent any case of cancer from occurring but prevention is possible. We therefore strongly agree that this needs to be reflected in Australia's mental health policy. Our only concern is that while the draft report does mention prevention and makes several very important recommendations that will contribute to this endeavour, in our view it falls short of outlining the full extent of both what is possible but also what is required to prevent mental health conditions among the Australian population.

First, just as a point of clarification, it's our view that prevention is the not the same as early intervention. Prevention, or primary prevention, focuses on stopping the occurrence of a condition while early intervention focuses on early detection and treatment of a condition that has already developed. Preventing mental health conditions requires a public health approach. While early intervention is largely a mental health endeavour requiring access to clinical and psychosocial supports and services, a public health approach is an approach that focuses on groups and communities rather than the provision of one to one services.

It seeks to influence the underlying root causes and the upstream determinates of mental health conditions, that is risk and protective factors rather than treating the condition, it does this by supporting individual behaviour change as well as improving the social environment around people. It therefore requires multi-sector action most of which needs to occur outside the mental health system in the home, education settings, workplaces, local communities and online to mention a few.

Its tools include public education social marketing campaigns, personal skills building programs such as parenting programs and resilience programs, the creation of mentally

healthy organisation environments and mentally healthy public policies; we need to put policies in place to tackle some of the underlying risk and protective factors. So it's really a mixture of campaigns, programs and services rather than clinical and psychosocial supports and services.

At present most of the mental health funding in Australia flows to mental health care and substantially less flows to prevention. As a result I do not believe that Australia has a prevention system that is sufficiently robust to seriously reduce the incidents of mental health conditions in the community but we can create one. Instead what we have is a series of largely disconnected prevention initiatives that target some risk and protective factors but not others, in some settings and not others and rather than a coordinated and systematic approach to prevention in the mental health field as we try to have in other parts of the health field, therefore while we support many of the recommendations in the draft report we do not believe that this is all that could or should be done.

Yes, we urgently need to scale up some of the known evidence-based prevention and intervention mentioned in the draft report but we also need to build a strong prevention system or really what we should be building is a strong mental health promotion system that can focus on promotion prevention, suicide prevention and, you know, some of the aspects of early detection around help seeking destigmatisation. It is therefore our hope that the final report will put greater emphasis on prevention by including it perhaps in a separate section to early intervention and by setting out more recommendations for how we can build an effective system.

Prevention in the mental health field is both the same and different to prevention in other health areas. The public health principles are the same but the complexities magnified because of the large number and wide range of underlying risk and protective factors that need to be simultaneously influenced, ultimately we therefore need to answer the questions, 'Which risk and protective factors can we tackle using what interventions, through which settings and for which age groups and how will we establish, coordinate monitor and resource this?'

Ideally the final report should therefore outline some of these risk and protective factors. In our view preventing adverse childhood experiences, some people call them 'ACEs', in particular child maltreatment must be a central aim. Childhood trauma, child maltreatment, is the single biggest preventable risk factor for the occurrence of a wide range of mental health conditions and suicidality. It is estimated that preventing child maltreatment would prevent around one-fifth to one-quarter of all new cases of depression and anxiety disorders and also contribute significantly to the prevention of self-harm and suicide.

Another major risk factor that needs to be tackled is social disadvantage. The draft report highlights the very strong association between socioeconomic disadvantage and the expense of mental ill health but the recommendations fail to indicate how governments should tackle this. Ideally the final report would also mention more about the known evidence based approaches to prevention are particularly those that are ready to take the scale. The report mentions some of these including some parenting programs and social and emotional learning programs but there are far more evidence based approaches particularly for schools that

could be used to prevent depression, anxiety, conduct disorder and even substance misuse particularly using CBT strategies.

Again in terms of the settings we totally agree that antenatal services (indistinct words) schools, universities and workplaces are ideal but there are other settings; in the home, place based approaches through local council - what is the role of primary health care in the prevention of mental disorders and what about the online environment? There are also existing organisations that are doing a fantastic job that could be better resources to also focus more explicitly in prevention. Beyond Blue is already doing a lot of good work (indistinct words) but Headspace can also potentially play a bigger role in prevention as well as early intervention.

And ideally the final report should also consider how we would - you know, how it does with the mental health care initiatives - how we would select and implement these initiatives, accredit them, how and by whom they would be delivered and they would be integrated and coordinated as well as measured, monitored and resourced? The report talks about the early years educators/teachers and OH&S personnel but it puts a lot of pressure on those individuals when maybe it's time to employ suitably qualified mental health promotion workers to support them rather than expecting them to become mental health experts.

And lastly I think we need to focus on who is going to and how we are going to pay for these prevention initiatives. For me neither the renovate or the rebuild model adequately addresses the issue around prevention. So ultimately for us the draft report is an excellent starting place but it's not the finishing place. It makes several very important recommendations which we support, and I can go into, but the focus of this inquiry is on the personal social and economical impacts of improving the way we address mental health in Australia and mental health is not just the absence of mental illness, it's far more than that therefore we fully support the Commissioner's views that improving our mental health care or how our mental health care system is structured and functions is central to achieving this but we also believe there would be considerable benefit in focusing some resources, more resources, upstream to promote mental wellbeing and prevent mental health conditions from arising in the first place. To focus on the mental health care system supports the 20 per cent of Australians living with a mental health condition to also focus on promotion prevention allows us to cover 100 per cent of Australians. That's what we do in other areas of health and that's what we will need to do with mental health as well. Thank you.

**PROF KING:** Thank you. If I can just start off, you mentioned childhood trauma, child maltreatment, and completely agree with you on its importance and the significance and we've made recommendations around perinatal childhood health checks so I guess my question is, and clearly you think there's something missing there, what practical on the ground recommendations then do you want us to make to government so we're heading towards May next year and there's, you know, a couple of recommendations but it's got to be saying, 'The government needs to do the following, it has to be implemented'. Well, what would you want us to do?

**DR CARBONE:** Yes, so taking up the point about the importance of recognising and managing perinatal mental health conditions, so absolutely agree with that. But I think it's a little bit, as my colleagues from Beyond Blue had said, it's not just about screening it's what

you do then and I think you need to think about whether parents, particularly expectant parents or new parents, should be a group that requires fast tracked quick access, you know, to mental health services particularly if they have a diagnosed mental health condition, substance misuse condition or some other, you know, vulnerability in their lives which would perhaps impact on their parenting and they need to be given the most support that we possibly can; practical, financial, emotional and clinical and psychosocial supports, so I think it's beyond screening and into what other services are we recommending, you know, that parents, expectant parents and new parents, have access to but there's also research to suggest that you can use the time, you know, the antenatal period to prevent conditions like depression.

There are CBT-based interventions, for example, that could become part of antenatal classes or parenting programs. They could also simultaneously be helped to avert depression before it arises in that antenatal period so I think it's really just broadening the recommendation to look at, you know, 'Okay, here we have a population in a particular setting of antenatal services; how do we maximise that engagement that we have to both focus on prevention and early intervention because they're a critical group?', you know, parents throughout the life - you know, obviously parents with older children and adolescents et cetera but at that crucial first three years of life, first 1000 days, make sure you maximise your supports and services.

In regard to social and emotional wellbeing screening, again I think it's the same thing. What are you going to screen for and how as my colleagues from Beyond Blue said. If I think you're screening for disorders that might not be the right approach. Perhaps what you should screen for is the risk and protective factors and, for example, some colleagues from Royal Children's Hospital, Murdoch Children's Research Centre, which suggest you need to screen for is exposure to ACEs so if you know that a child has been exposed to one of the several known adverse childhood experiences connected with mental health conditions in childhood adolescence and later in life, screen for those and then intervene to try to, you know, deal with whatever's happening in the background so you're better off dealing with the cause rather than the symptom or the condition that flows from that because then that will, you know, basically help to short circuit the condition anyway. So that's an example of how you can build on that recommendation to make something a little bit more specific.

I mean on that, and just as an aside, the Federal Government announced after the Royal Commission into child sex abuse, institutional child sex abuse, that they were going to establish a centre for the prevention of child sex abuse. That's a great initiative but there's capacity to broaden its scope to look at all forms of child abuse and neglect. There's also capacity for broaden it beyond child maltreatment into childhood adverse experiences, childhood trauma, of one form or another so I think you need to think beyond the small and particular to the bigger and generic sort of underlying categories of things that contribute to poor mental health.

**MS ABRAMSON:** Thank you and, Dr Carbone, thanks for coming today to present. I don't know if you're intending to present a submission to us but we'd be really interested with a comprehensive list of the evidence-based prevention approaches that you think actually we should have a look at. And the second point to that is a funding issue. We've gone to some trouble in the report to think about, 'Well, what should be funded on a national basis by the national government and what should we fund on a State base?' but we're very open to what you've said about prevention but we need you to put some breadcrumbs down for us so that

we can say, 'Okay, well we need to look at these other areas as well' and happy for you to take that on notice.

**DR CARBONE:** Yes, and we will be making a submission so, yes, happy to include a list of those.

**MS ABRAMSON:** Thank you.

**PROF KING:** And thank you for going through that and I think for us part of it what should be delivered universally for all families, for the whole of Australia, and then identifying the higher risk groups that might have an aggregation of those risk factors that you've mentioned and targeting some interventions in that area so some of the interventions therefore could be part of what the original commission authorities that we've recommended take on because it's a local targeted intervention versus universal national perhaps run for the whole of Australia not specifically at local levels through the RCAs. Any comments that you might have in the submission about which area is the best way to get that intervention out would be valuable as well.

**DR CARBONE:** Yes, look, I think it's a complex area, I mean, as you know the more universal the intervention the smaller the effect size but the bigger the population that experiences the benefit and therefore at a population level it certainly is value for money but clearly, you know, the more that you can then define (indistinct words) groups that might be at particularly high risk the more likely therefore that they're going to have a better experience or more benefit but they're a smaller group but it's that tension between as you know, you know, getting the whole of the population to the left side, the mental wellbeing side of the continuum versus, you know, more targeted approaches. I think the problem that, you know, you often get with targeted approaches is determining who to target, you know, it's not always easy and that then leads to also potentially the issues of stigma.

You know, if you're selected out for some sort of special treatment, you know, they're, you know, - and this part of the problem with current approaches to parenting programs for, you know, vulnerable families because the uptake of, you know, highly evidence-based interventions like PPP, you know, is low because they're too stigmatised, you know, and you need to make those sort of programs more acceptable than normal and more people will access them because it's not like people won't benefit from them, it's just that some people will particularly benefit from them so I think we can make some comments about that.

**PROF WHITEFORD:** Thank you very much.

**DR CARBONE:** Thank you.

**PROF KING:** And our next present is Mouradian, I hope I've pronounced that correctly.

**MR MOURADIAN:** Mouradian, yes, is my name.

**PROF KING:** Please if you can come down and just state your name, if you are representing an organisation then please state that.

**MR MOURADIAN:** I wish I was (indistinct words) I'm just by myself, isolated.

**PROF KING:** All right so just please state your name for the record and any opening comments you'd like to make.

**MR MOURADIAN:** Yes, my name is Vikein Mouradian and I'm presenting as an individual and I believe that presenting as an individual gives the Commissioner or the Productivity Commission a different perspective than what we've heard from the organisations that have spoken although, you know, very eloquently and very genuinely so I appreciate that but nevertheless I believe I can offer a bit of a different perspective about mental illness and in particular I want to relate it to work.

Now, Clive Palmer said, 'Jobs, jobs, jobs and more jobs' so that's the point that I want to relate because you are the Productivity Commission and, you know, obviously the more people working, the more the government gets money as a taxpayer. And some would argue that it's also beneficial for the worker, although I would say probably not, if you have any mental health issues.

My personal experience in the matter has sort of shown that not only if you have mental issues, but if you're perceived to have mental issues, what happens to you is, you get the police sent after you; you get locked-up in a mental institution, then you get the police sent again, even though you've been released from the mental institution by the employer.

In another instance, you go to court, you get fined \$800 and given a criminal record by the employer, even though you've left the job; you get told by your union that, "They're not going to help you because they believe you're mentally ill." That's the union where I worked. And another one is your own organisation, the Australian Public Service Commission; you get told by the delegate of the Australian Public Service Commission, "We will never employ him," even though the AAT member - that's the Administrative Tribunal - member says, "Well, can you review the matter in about six months?"

The doctor or the Commonwealth Medical Officer and the Public Service Commissioner, or the delegate; he says, "We will never employ him." So, there presto, you don't work. So what happens is, the government loses, if you're talking about monetary sort of angle, from the monetary perspective. And as the Productivity Commission, I'm sure that's one of your tasks, to get the productivity going.

And in fact today, we even have the Treasurer Josh Frydenberg talking about this very issue of working. He claims, you know, there's been a 20 per cent increase in people 65 and over - and I'm 65, not over - so that's what the government is talking about, and they're talking right, in my view. They want to put people in work, because they're concerned, probably not so much about your mental health because they're concerned all this taxpayer revenue.

So I don't think they're really concerned so much about your mental health, but they are very concerned about getting the budget right. And of course, you've got to get the budget right, to get people working; the more people work, the better society we have. That's one of the key fundamentals of being in a society, especially in Australia where, you know, people work



very hard. So I actually want to get good mental health; obviously, you know, work is the basic foundation: if you're building a building, that's what you need.

So that's my perspective. I've had a lot of trouble because I can't say many things, it would attract defamation action.

**PROF KING:** Yes, thank you.

**MR MOURADIAN:** So I'll refrain from saying. But I gave you what happened to me; that was three jobs, three things. And one job in a hospital claimed I'd been threatening the staff; I'd never been near the staff, never even been near - he wanted to protect some woman. I've never been into that woman, I had no interest in that woman; I haven't had anything close to it, I haven't even tried to contact her.

The second one, at the Tramways, that was dealt with very harshly, after working 19 and a half years as a tram conductor; a very, very difficult job. You get three death threats, punch-ups, spat on, all kinds of things happening. You're working 24/7 hours of the week, getting up 4 o'clock in the morning. I didn't get up properly this morning, even though I thought I'd come early, still got out of bed at 7.

Then, the public service. I don't quite understand why the Australian Public Service Commission is so intent on you know, not taking anybody that they believe is perceived as mentally ill. As one of the speakers said, I think it was Beyond Blue, low intensity, it's low intensity. Now, there is no employer in Australia will employ anybody with low intensity mental illness, or perceived mental illness, and there is a lot of work to be done.

So my point is how society interacts with you, if you - you don't have to be mentally ill, that's the point. You know, you could be, you might not be, because you know, some people - you might look at somebody and you might think they're mentally ill; they might not be. You might look at somebody and your point of view might say, "Well, he's quite normal," but he might be more mentally ill than the other person. So it's a matter of perception, of how you look at it.

What I was going to say is, so why this insistence? I mean, the AAT delegate - this was a long way ago, a long time ago, but it does demonstrate as the problems you meet, because like I say, jobs, jobs, jobs; that's what Clive Palmer said, that's what we want, that's what's essential. And more jobs, he said, he said, "Jobs, jobs, jobs, and more jobs." Now, he's a bit of a flash sort of spin doctor, but that is you know, it's not that I not only agree with him, but that is the fundamental fulcrum of society.

**PROF KING:** Can I ask you, just on - - -

**MR MOURADIAN:** I want to finish off.

**PROF KING:** No, keep - - -

**MR MOURADIAN:** No, you go ahead, yes.

**PROF KING:** Yes.

**MR MOURADIAN:** I'm not a very good listener, sorry. My apologies.

**PROF KING:** Just with something like the Tramways Board; so it's a dual - - -

**MR MOURADIAN:** Used to be the Trams Board, used to be the Metropolitan Transit Authority.

**PROF KING:** Yes, so it's a job which has significant stress, as you said; it's early morning starts, you're getting abused by customers, there's - - -

**MR MOURADIAN:** Death threats, yes, the three of them.

**PROF KING:** Yes. Do you have any thoughts about the support that would be needed in those sort of jobs; what was missing when you needed support, when you needed briefing, whatever it is, in that sort of job? What was missing?

**MR MOURADIAN:** Well, the tramways is not a job you choose; it's a job that chooses you. It's not a job that people go in and say, "Oh, I want to be on the trams," nobody does that. Its people go there because they want to work and they can't find anything else, or they can't do anything else; it's a combination of factors. So it's more or less a compulsory job; you're really being pushed into doing this, if you want to work. You want to be unemployed on, you know, \$200 a week, well, that's fine. You know, most people like to have a bit more money than that.

So you could get more money, but it's not - what I mean is, when I worked there - I don't know now; they claim that the drivers of trams are getting \$90,000. Now, that's now when I worked there; when I worked there it was long hours and low pay, it could be characterised as too. And the reason for the low pay was because they said they would give security of employment; and as it happened, you didn't get security of employment because you just wasted your time because they sacked the whole lot.

The tramway terrain is very complex; it has a lot of migrants there, all right? It's a big migrant workforce. And it has two unions; now, I don't know whether it's still there: there's one union representing the clerical staff, and there's another union representing the tramways staff, or the platform staff, whatever they call it. So the two unions are in conflict with each other.

The other union, the union representing the tramways staff is getting much better pay and much better conditions, while the union representing the trammies, or the platform staff, is on low pay and has very bad conditions, very long shift-work. And it has very bad managers, not only inexperienced managers, but very racist; you know, you would think somebody that employed so many migrants would give some cultural training, because it is difficult to deal with a lot of different nationalities, I concede that.

You know, I find it difficult myself, you know, with the high rate of migration here in Australia; I have difficulty - no, not necessarily difficulty - I have a certain adjustment effort

to do, to deal with all these people, with all these different nationalities. I mean, I go to the shop, I meet a Chinese, then an Indian, so I have to sort of culturally adjust in a single day. Now, it is very difficult, and the tramway management puts somebody there that's - I mean, he calls me in and he makes out that I can't speak English, and he talks to me in broken English; now, if that's not racism, I don't know what is. I mean, that's definitely racist.

And my late mother goes there, gives him back my uniform because I didn't want to go back to the depot, and he does the same; he talks to my mother as if she didn't speak English, because she was a migrant. But as a matter of fact, my mother spoke real good English because where she came from, she worked for the Royal Navy during the wartime, so she spoke really good English. So that was so prejudicial.

And his clerks, these clerks, I meet somebody, a clerk, one of these clerks in the street, and he makes out that I'm mentally ill, "Oh yeah," he starts mocking me. And this is when I left the Tramways, I met him down in William Street. And they're always carrying on, the attitude, the whole attitude towards the mentally ill, or perceived to be mentally ill. Because, like, the Tramways has all types of people, like, it's a variety of people; you can go from top to bottom. Most are okay, the platform staff, they're pretty reasonable, they all work hard, whatever you might think of them.

But these people, they have a very sort of this approach of the employer, of his clerks, of his administrative officers, who are supposed to show leadership and they're sort of having a go at people who are perceived to be mentally ill, you know? And it's a big organisation the Tramways, and it provides a very essential service, and yet you know, it's failing its duty of care to the employees. You know, it's a complex organisation, not because - I mean, running the trams is not all that complex - but it's complex in terms of their employees.

Because you know, this is getting a bit racist here to myself, but I mean, there is all these cultural factors, and this is a big issue, you know? If the Commission wants to look at the cultural factors, because a lot of workplaces now you've got all different nationalities, and that takes a lot of - it's a different style of management you've got to adopt. And it's something that maybe you know, the Commission wants to look into.

**PROF KING:** Yes, that's good.

**MR MOURADIAN:** Yes, I don't want to talk too much, but you know, they are important issues, I think.

**PROF KING:** Okay. Just the one final question: so you were involuntarily detained?

**MR MOURADIAN:** I was at the Royal Park Hospital, yes.

**PROF KING:** Yes.

**MR MOURADIAN:** But it was released and he sent the police again to get me, in the afternoon. I was released.

**PROF KING:** Yes.

**MR MOURADIAN:** This is not a joke. I don't want to be in there, I don't want to be an involuntary psychiatric patient; I don't think anybody does. Anybody that tells you is lying. I don't like being in there. I was legally and lawfully released, so why is he sending the police again in the afternoon, to have me - this is a type of - this is what happens to you if you're mentally ill: people seek revenge.

I mean, if you want the psychoanalytic explanation of it, I think it's because, you know, this is only a hypothesis, but it is a valid point because when you see somebody that's different than you, right, and you see that in yourself, you want to fight it; you want to say, "Oh, I'm not like that." But really, we all have - as human beings, we all have the same symptoms to a degree, as somebody as you might see, call him a raving lunatic. So you fight it, you're seeking revenge, you're saying, "No, I'm not like that. I don't want television and see people," you know, "talking to me." You say, "I don't do that."

So if you see somebody saying, "Oh yeah, I do," you know, "I'm sort of mentally ill, I do see people talking to me, 'Oh look that guy is talking to me,'" you say, "I don't do that." So get the fella that's saying that, as a matter of securing my own self, as a matter of saying, you know, "I can't be doing that. I can't be saying," you know, "Obviously, the fella is nuts, because he's saying to me that, 'The people are talking to me on the television.'" So there's this seeking of revenge.

And hopefully, these inquiries and things like that are going to improve this urge of citizens of the state of Victoria or whatever, whatever they are, to seek that greater understanding of mental illness, to seek that sort of revenge that they want to get. Because this guy in the psychiatric hospital, he was just seeking revenge, it's all he's doing; he's not treating me, he's not doing anything. He's just get me locked-up, I haven't done a thing, I haven't been near that woman.

**MS ABRAMSON:** Could I ask you a question about the involuntary - - -

**MR MOURADIAN:** Yes, I don't want to go there.

**MS ABRAMSON:** No, absolutely not. All I wanted to ask - - -

**MR MOURADIAN:** No, I mean I don't want to go back there.

**MS ABRAMSON:** What I wanted to ask you is, we've got a very strong view that people need to have representation as part of that process; did you have any legal advocacy, or an advocate that looked after your interests, or you were just subject to the process?

**MR MOURADIAN:** Well, this happened in the 1980s and there was no process then. The process was really discretionary; it's basically based on the doctor, so it was very discretionary. But now we have the Mental Health Review Board, we have other things. But my personal view is that the discretionary procedure that they had before is better than the Mental Health Review Board, because that institutionalised you. They say, "Well, you can't leave because the Mental Health Review Board said."

But the other way, always discretionary, it was totally discretionary. There was no Mental Health Review Board, there's no rights, there's nothing; it's just up to the doctor, so you had to sort of beg to the doctor to let you go. So the discretionary way was better, because you can see the injustice. But if you're saying the Mental Health Review Board, well, that's an official body; they say, "Oh no, it's like a court," you know? You've been, that's it, the Review Board said.

In fact, it's very hard to get out of a community treatment order; in fact, the community treatment order you're really on it for life, much more than if you go to jail, because with jail you got to set a minimum you do, well, you get out of it. But you won't be getting out of the community treatment order, and it's controlling you in the community; it's like what they say, judging the community, which is pretty hard stuff, you know? You've got to go to a case worker every few weeks and take your tablets, and they inject it, so it's better not to be mentally ill.

**MS ABRAMSON:** No. What we're thinking in that regard though - and we've got some evidence around this - if you had the ability to have an advocate appear with you or for you - it doesn't have to be a legal advocate - there is evidence that people were less likely to be involuntarily sent for treatment. So that's why we've been focusing on that area.

**MR MOURADIAN:** Well, he would be more in the public eye; I mean, the doctor would be more in the public eye. So that puts him more - you know, makes him more publicly accountable. If you really wanted to press the issue with doctors in the mental health field especially, they've got to be made more publicly accountable; I mean, they're a very powerful group. And they're more powerful than the police, really. And you know the police are so powerful, that when you compare the power that they've got, they're even more powerful, so they're a very powerful group.

So we've got to be more publicly accountable; that's a very hard road to sort of get, because the doctors will resist that. They won't cop that, because they like to, you know, keep their power, so if you take away a bit of their power, even an inch, I don't think they will - if anybody can do that, you know, that would be great, if any organisation or government can do that: make them more publicly accountable.

I mean, you know, the judges and magistrates - I don't know about magistrates - but judges, every single case this week on criminal matters, they've given their reasons, you know? It's in the daylight, the sun. But with the doctors, it's underneath the table.

**MS ABRAMSON:** No, no. Look, thank you for coming to give us your evidence.

**MR MOURADIAN:** Yes, no worries.

**MS ABRAMSON:** Because I know that those are not easy things to do, and we really value hearing from you.

**PROF WHITEFORD:** Yes, thank you very much.

**MR MOURADIAN:** Yes, no worries. Thanks for your encouragement and all the great people that are in the room too; they've been helpful.

**MS ABRAMSON:** Thank you.

**PROF KING:** We'll just take a 20-minute break? Yes, I'm getting nods there. So let's take a 20-minute break for morning tea, and then reconvene; so see you in 20 minutes. Thank you.

## **SHORT ADJOURNMENT**

## **RESUMED**

**PROF KING:** Let's recommence, and can I invite Maggie Toko to come down the front? And if you could, for the transcript, state your name, the organisation that you're representing, and if you have any introductory comments you'd like to make.

**MS TOKO:** So good morning. My name is Maggie Toko; my iwi is Natubatah and Napuri, and I am from Aotearoa. I am the CEO of VMIAC, which is the Victorian Mental Illness Awareness Council. My opening comments are, I wish to talk about the value and importance of consumer participation in service design now, and into the future; and the importance of co-design in service management and delivery.

VMIAC is a peak mental health consumer organisation in Victoria, and we are an organisation that is consumer-based; both staff and the committee of management have a lived experience with mental health. We have recently formed an alliance with five other consumer peaks, representing Western Australia, New South Wales, South Australia, the ACT and Tasmania, to form the National Consumer Alliance.

I welcome the Productivity Commission recognition of the importance of consumer and carer engagement. On this occasion, I will reference my statement to consumers. The principle too is to build a mental health system that is truly person-led. I recognise that the draft report has the intention to place consumers at the centre of their care; there are references to psychosocial support and social determinants of health, but I feel these are without true understanding of what it means at the coalface, for the consumer on the ground.

Psychosocial support is someone who can walk your journey of recovery with you, as the consumer; to support changes as you change. Psychosocial support is not a quick fix. It is about a relationship building, relationship modelling, it is about identifying and developing skills you already have as an individual, as a partner, as a couple, as a family. Psychosocial support assists with your recovery journey. Again, your journey is not a quick fix. Journeys of recovery can be a lifetime thing. Having a mental illness should not be a lifetime sentence. Having a mental illness doesn't mean that you are unable to be productive, that you are unable to contribute to society. It just means that you contribute in a different way.

Consumers want to have a say in what happens in their lives. They want to be able to ask questions about their care. A system that has consumers at the forefront of care is a good system. As a society we should want to grow the foundations by having consumers participate in service design. It should not be just about what I can receive but what I can put in. The term 'recovery' needs to be defined so that when decisions have been made by the COAG health council they have an established view of what it means for the consumer. A system that is person-led will prioritise the importance of co-design and service management and delivery. A peer-led workforce that is enabled to develop skills and qualifications and match other streams will be important to the future of those workers who have lived experience.

A commitment by state and territories to acknowledge the lived experience workforce as a viable addition will generate a commitment to the value of co-design. I believe that we as consumers have the ability to participate in all levels of the development of services, not only as the users of services, but as core contributors by management and staff personnel, not as a stand-alone stream that is a collaboration of services and workforce. To influence the future, we need to be part of it. The issue of stigma features here due to a belief that having life experience lessens your ability to function on an everyday level.

VMIAC is living proof that you can have lived experience and function on a high level. I acknowledge that this is not the case for all consumers, but it is not because of who they are but more to do with the social determinants that influence their available choices. Peer-led services currently exist in countries like Aotearoa, England and Canada, to name a few. They are models which we should be encouraged by. That's the end of my submission.

**PROF KING:** Thank you. Would you like to start or will I?

**PROF WHITEFORD:** You're fine.

**PROF KING:** Okay. Your comments really related to consumer involvement, peer involvement in both design - all aspects of design and delivery of the services, and you said that you would like to see commitment to recognise peer involvement at state and federal levels. Hopefully we captured some of that in our recommendations. For example, when we see commissioning bodies that they should have peer representation or consumer representation on their board, at board level, so at a high level in those organisations, and that was our attempt to come up with a practical way of making sure that consumers are involved in that design. Do you have any other practical on the ground suggestions as to where we need to embed consumers, peers, in the system; make sure that that voice is always heard at every level?

**MS TOKO:** I think some of the practical things, I'd have them at the beginning. I have a younger sister who lives in Aotearoa and works for a politician there and she had the job of escorting Jacinda around Hamilton when she had her discussion about the Henry Bennett Unit, and we talked about Jacinda talked about having consumers right from the get-go, from the first stone that was laid right to the creation of the new unit, and I think she hits the target. She hits the mark, which is at the first foundations that are laid you have consumers there, then you're starting - it's not the - what is it the carrot for the donkey thing?

**MS ABRAMSON:** The cart before the horse.

**MS TOKO:** Cart before the horse, that's right. So you're not starting that way because that way consumers have to fit into that system. But if you actually walk side by side, and it is a lot like that recovery journey. The recovery journey is about taking it at your pace and I understand with economics that the pace is often a lot faster than it otherwise should be, but it's actually at a pace that grows with the recovery, and I think that it can be fashioned into something that is equitable for everybody, and an example of that is that - if I tell a little bit about my own story is that I recently had a health scare - well, the last three years have been a health scare because I've been treated by Peter Mac, and Peter Mac wouldn't think to do a single thing without me being part of it, without me saying what I want to happen, with me saying - without my partner saying what she would like to happen, without my friends saying what they would like to happen, and everybody is involved, and sometimes I think in the system that we currently have everybody is separated.

They're in their own little cohort, and no wonder there's no togetherness, and I was talking on the break with Gus and we were talking about New Zealand and some of the - you know, because there are a few steps ahead and what they do in mental health, and I wondered because it's a whole of - there it's a whole of government understanding, and I wondered if that was because of the culture that underlies the country, the Pacific Island Maori culture, that it's quite embedded in society, whereas I really feel for the indigenous people of Australia because they're quite separate to what's happening, and perhaps if their culture was embedded the same way that it is in Aotearoa, then systems that develop would develop with that culture, that kinship feeling and those types of things. Does that make sense?

**PROF KING:** Yes, yes.

**MS ABRAMSON:** Absolutely. I wanted to ask you - thank you for taking the time to come today too. I wanted to ask you about stigma. So we've heard a lot of evidence around this from whether it's with young children and people seeking treatment because they don't want their child to have, inverted commas, the stigma of mental ill health. We've thought from the point of view of national campaigns around it, but we're really interested in practical recommendations, especially based on your international experience, of what we can do to change the public conversation.

**MS TOKO:** Well, I think - I heard of a campaign where they just say, 'Who's your neighbour?' not what stigma is, not identifying stigma as such but, 'Who's your neighbour?' And I know I'm working with Blueberry and Tandem Carers looking at a campaign around, 'Who's your family?'. Not, 'Your family is your mother, your father, your sister, your brother,' but 'Who's your family?' It is who you say your family is, and I think that's the kind of campaign that should happen with stigma. Just, 'Who's your neighbour?' People don't know who their neighbours are. People don't have a sense of community. There are individual communities scattered around, but you want a whole response from a huge community, from the country, really, around stigma. Stigma - I think campaigns that deal quite clearly with developing community are a good way to go.

**MS ABRAMSON:** Yes.



**MS TOKO:** I think campaigns that talk about stigma - I prefer and VMIAC prefers to talk about discrimination because discrimination is against the law. Stigma, you can say you're looking at stigma, but if you discriminate against somebody it's against the law and people listen to that. But you don't want a society that's brought up with, you know, overly law-abiding-centric. You want a society that wants to embrace, and maybe it's about embracing your neighbour.

**MS ABRAMSON:** Can I ask, based on that, about community participation because we know that social participation and we've outlined it in our report, is incredibly important, but what type of practical recommendations can we make that would start us on the path that you're talking about?

**MS TOKO:** Well, VMIAC released a declaration two weeks ago and part of that declaration was how we would like to see the service system. In our ideal dream world, how would we like to see it? And we surveyed many consumers, who came up with different words for what they were wanting. For example, some were saying they didn't want psychiatry, others were saying they wanted psychiatry, but they wanted psychiatry just as much as they wanted yoga. The wanted psychiatry just as much as they wanted massages. Talking therapy. Those were things that people talked about. But in terms of consumer participation, it's really community participation. It's really owning who your neighbour is, owning who you are. I think owning who you are is a bit difficult because, you know, years of analysis. We're not going to get there, but owning who your neighbour is and what your neighbour does and what your neighbour sees and how your neighbour lives. It's actually a worthwhile thing.

One of the things - we recently had our conference and we had a youth conference at the beginning of the week, and I talked to young people, because I have 20 years' working with young people with mental illness, and I talked about one the things that we used to do in this youth serviced that I worked for was feed young people, and when you feed them, they're full, and when they're full there is no mischief that happens because there is only time to talk, and if you listen and you're available, then they will talk. It makes sense.

A lot of organisations and the department would say, 'What is it that you do there? You must do something because the violence rates are down and crime rates are down in that cohort of young people that you're working with,' and I said, 'I just feed them. Just provide a sense of community. I feed them and I feed their families.' They're just as hungry as their families. The families are just as hungry as them. It's not a big deal. It doesn't actually cost that much to cook a roast and to feed a group of young people, and I think that's what it is. I think people think that - and maybe the Productivity Commission is in that position where people think that you have to spend millions and millions of dollars. It's very practical.

**MS ABRAMSON:** We're keen on spending the taxpayer dollar quite wisely. But it's a really interesting conversation because we had a submission from the Library Association and it was a really interesting submission that I might not, to be honest, have thought of otherwise because they have become hubs for people, so that brings community in, and often for people who are quite socially disadvantaged, so it was those type of things, and I really listened to what you've said this morning, so it was those type of initiatives where we thought, 'Well, that's actually really interesting and it's not a high cost.'

**MS TOKO:** That's right, it's not a high cost. We run probably 15 forums a year at VMIAC, where consumers can come, where their families can come, and we have guest speakers and we have different campaigns that we're running and things like that, and one of the things that my staff do really well is they just listen. So my job when we run those forums is cook the barbecue, so I'm feeding again, so that's my job and then everybody else gets to listen to what the staff are saying and things like that. It's not that expensive to gather community together and that sense of wellbeing that is priceless. You cannot get that from - you can probably get that from joining a sports club, but for many consumers the price is out of their range.

**MS ABRAMSON:** Yes, I understand.

**MS TOKO:** But it is priceless when you bring them together and loneliness is a very big factor. I know having worked with young people, loneliness is one of the killers of young people, so they get housing, they get housing on their own and they can't survive because there's nobody else there with them, or they get put into shared housing that they don't get to choose who their housemate is and it breaks down, and again, it's a killer for young people and it is for aged as well.

**MS ABRAMSON:** I don't know whether you'll be putting a submission in, and we can just have comments. We've got a comments section. But some of the programs that you're running and that you're involved in that encourage social participation we'd be really interested in.

**MS TOKO:** We can certainly do that.

**MS ABRAMSON:** Thank you. That's really interesting.

**PROF WHITEFORD:** Thank you.

**PROF KING:** Thank you very much. Next is Charlotte Jones.

**MS JONES:** Can I just give you something?

**PROF KING:** Yes.

**MS ABRAMSON:** Yes, thanks very much.

**PROF WHITEFORD:** Thank you very much.

**PROF KING:** I will state just one thing. Obviously the transcript hasn't got the diagrams and so on, so if you can avoid sort of saying, 'If you look at diagram X,' and so on.

**MS JONES:** That will be fine.

**PROF KING:** If you could just state your name and organisation for the transcript and any introductory comments.

**MS JONES:** My name is Charlotte Louise Jones, I'm the general manager of the Mental

Health Legal Centre. We did place in our submission before the Productivity Commission explaining what we do. We've existed since 1987 representing people with a mental illness in detained environments across Victoria. The focus of our work is mainly inside prisons and locked wards, but in recent years we've branched into health justice partnerships. We've run two for the last four years, one's specifically on our advance statements and one specifically with the Bolton Clarke Homeless Persons team.

So I was particularly keen to discuss today the part of the submission where you said that you were lacking information in the evaluation of health justice.

**MS ABRAMSON:** Yes, we're very interested.

**MS JONES:** I'm very interested too. I'm very keen to talk about them. Our advance statements project has a very lengthy university document that was produced by RMIT that was fully evaluated for us by Dr Chris Maylea, who works that in conjunction with us. We also worked with VMIAC on that work as well to make sure that we had the strongest possible consumer voice on it, and it went into some very complex environments.

The documents I've given you today specifically relate to our health/justice partnership. What we aim to do at the Mental Health Legal Centre is we have an outcomes evaluation framework that sits across everything that we do, and that means that everything is evaluated on a continuous basis.

What's really important to us is that we know what our stakeholders are thinking, what our consumers are thinking and what our staff are thinking about what we're doing so we can actually drive a project forward. That's at the core of us. Does that help?

**MS ABRAMSON:** Yes. Just understanding a bit more about the health/justice partnership.

**PROF KING:** What exactly it does, yes.

**MS ABRAMSON:** What they are, how they function, and then I might, if you don't mind, come to some more specific questions that we want to ask you.

**MS JONES:** So health/justice partnerships are an alliance normally between legal centres or another service support and they can go across financial counselling and social work, along with an allied health professional group. We've found we work best with nursing teams and social work teams in the environments we've worked in. We tend to find there's a commensurate level of numbers and not the same pressure, so for the doctors and the psychiatrists it can be more complex. Yes, they'd love to engage, but they have a bigger problem, as it were, on the side. What the nurses and the social workers find is they're trying to solve some of these social problems, so the interplay works better. I've witnessed that across a number of the health/justice partnerships that we have operating in Victoria. I would specifically speak to the MABELS project that I know information is also available on, which is a mother and baby family violence project, and there is a large report that we can send you on that. I should be able to get a copy and forward that. That would not be a problem.

In regard to our health/justice partnership, it works with a group of nurses who work with

either the street homeless or those threatened with homelessness, which the vast majority of experience mental health problems.

What we did was we designed this project four years ago in conjunction with the nurses and their clients, and they have then led how it has worked. So everything about its development works on the basis of being fed into. It's not we go in and say, 'Hey, we've thought about a great idea.' It's about, 'What would you do if you had a lawyer? How would you make them work for you?' It's not about co-location. Ours works on the basis that our lawyer is actually in the office. One of the things we discovered that was really important in the early stages was that she had a mobile phone that they could ring. Over 144 of our contacts since the project began are just mobile phone queries saying, 'Is this a legal problem? Can we do something about this?' Or, 'What do I do with it?' That kind of consultation for health professionals has been immense and made a huge difference to their working day. It stops them puzzling over a problem. They just solve that. It took less than three minutes to make a phone call.

For the bigger legal issues they can actually calm a client down, so often what a nurse will find, in our experience, is that she'll go to see a client who'll say, 'I can't engage with my health problem. I have this other problem and it's far more serious and much bigger.' So the nurse will ring the lawyer, and they'll say, 'Really? You can just ring a lawyer?' and they answer the phone and she says, 'Yeah, that's what this whole scheme is designed to do,' and the client automatically engages with the lawyer.

It might be that that thing we can say is, 'Look, that's nothing to worry about. We can deal with that. It's not urgent. Nothing is going to happen today.' Or it might be, 'Yeah, it is urgent. The police are coming to arrest you. There is a batch of outstanding warrants. We'll go with you and we'll deal with it.'

The health/justice partnership has now prevented imprisonment of people, it's stopped the loss of homes, it's changed how people interact with their nursing teams and kept them in contact with them and we've also been able to measure health outcomes, so clients have now started to say to us, 'Yes, my health is better because I've had this service, and I can now engage in other services.' So we see it as a steppingstone for reintegration rather than a, 'We fixed this, now you fall off the ladder again.'

**MS ABRAMSON:** I have two questions. I'm really pleased you've come to give evidence today. The first one is how do people find you? Are you found through the medical model, for want of a better word, that we have nurses who say, 'Well, actually, we can connect you with a service,' or do the police connect clients with you? How does it happen?

**MS JONES:** In terms of the Bolton Clarke health/justice partnership, if you are either a Bolton Clarke nurse or the Bolton Clarke nurse is co-located in any of the services, they all know about us.

**MS ABRAMSON:** Yes.

**MS JONES:** We only have one lawyer who has dealt with 420 cases since this started, so she is rather busy. We would like to see a few more lawyers because we think there's the

demand, but it's proved that it can work and it can be effective, and that was the starting point of it. In terms of the advance statements, that was done across every platform. We put it in specific community mental health services, we put it into secure psychiatric services and we also just put out a general call, so now anybody can show up at our office on a Friday afternoon and have an advance statement written. We just sit there and it's done with social workers as well as lawyers. So we're trying to have an interplay where you don't just have to see one person.

**MS ABRAMSON:** So the advance statement; are you talking about how a person says, 'This is the type of care that I want if I become unwell.'?

**MS JONES:** Yes. Yes, but we tend to have a much wider input than that. I've talked to, actually, interestingly, a lot of police about them, and they're really interested in seeing them get used and be made available to them so that when they came to be at a premises they could say, 'Oh, we understand you don't like being called Ted. You like to be called Teddy.'

**MS ABRAMSON:** Yes.

**MS JONES:** And this is what's going on, or these are the things that you might be scared of, and to understand some of the back story. We don't see an advance statement as purely the legal document. We actually see it as a journey and how somebody engages with services, so that people don't make those mis-steps that automatically make people go, 'I don't want to talk to you. Please leave me alone. I'm really scared.'

**MS ABRAMSON:** Ms Jones, we've very interested in this because it also backs onto an area where carers said to us for legal reasons hospitals and medical professionals wouldn't share information, and it seems to me that an advance statement that you're talking about could also provide some of those consents so that people could have information shared with their families or carers.

**MS JONES:** Yes, and they can be signed - because they're a legally signed document, all of those things can be attached, like the nominated persons.

**MS ABRAMSON:** Yes.

**MS JONES:** The other environment I've seen them used in a lot and heard of them being used a lot is in aged care to give a picture of the individual possibly before they became unwell so that people understand things better. The story that I heard that I thought was fascinating was somebody who used to be a fireman, so every time somebody rang a bell for lunch, he would become incredibly distressed, and they figured that out and stopped ringing the bell. It's the really simple things that matter to people, but they're really easy to convey.

But they are quite nuanced. They need to be written very succinctly. I have had a couple of advance statements that went for 50 pages. It's a little hard to expect a medical professional or anybody else to sit and read that before they deal with somebody.

**MS ABRAMSON:** Can I ask, how are you funded?

**MS JONES:** Largely we're funded philanthropically. We have just received some money from the state government to support us with our work on the Royal Commission but, yes, the majority of our funding is philanthropic.

**MS ABRAMSON:** So your lawyers, if they need to represent somebody, they'd need to apply the usual channels for Legal Aid to do so?

**MS JONES:** Legal Aid generally doesn't cover most of our clients.

**MS ABRAMSON:** Because?

**MS JONES:** They fall outside the scope.

**MS ABRAMSON:** Because?

**MS JONES:** The infringement is not serious enough - - -

**MS ABRAMSON:** Although it can send them to gaol, presumably.

**MS JONES:** Even so, it's not quite serious enough. Often they will be told they might be able to see a duty lawyer on the day.

**MS ABRAMSON:** Yes.

**MS JONES:** Generally when our clients tend to show up what will happen is they're told, 'You fall into the too-hard basket and we can't see you today.'

**MS ABRAMSON:** Can I ask a couple of related questions? Mental health tribunals? Do you appear for clients before those tribunals?

**MS JONES:** We do. We managed to get to 200 this year. Again, it's an unfunded part of our work, but we do it with the support of the pro bono community across Victoria. We're very heavily supported by a group of law firms who come in and deliver that with us, so we just have a roster. We send out all the hearings we have on the books and we see who can pick them up.

**MS ABRAMSON:** We're very interested in some statistical measures, and you do have that bias, I could see from your work, because we have been told anecdotally that when people have representation before a mental health tribunal it's vastly different to them getting compulsory treatment, so something like 70 per cent of people represented are not sent for compulsory treatment, so anything that you could assist us on that front, we really would welcome that.

**MS JONES:** Yes, we can certainly send you some of our data on that. We did an analysis of the impacts of having a lawyer some time ago and we were able to pull down that treatment orders were dramatically reduced from the request to what was agreed, was dramatically lessened and the impact, yes, of having a lawyer present. I think our stats came out at about 82 per cent, was the difference in a treatment order being made or not.

**MS ABRAMSON:** No, well, we're very supportive of this so the data would be great. One final thing, and you will have gathered I'm a lawyer so I'm pressing you on all these issues. Prisons. So we had a recommendation in prisons that really went to standards of care because we thought, 'What can we practically do?' We're looking for really practical things in that space. Well, if we had people working on the basis that they would develop standards of care, so the standard of care in the community would be what the standard of care for your mental health treatment in prisons should be.

**MS JONES:** Yes.

**MS ABRAMSON:** So that's something practical we thought of because we're looking across Australia and different systems have different arrangements, whether it's corrections or it's Department of Justice. So we're really interested if you've got some ideas about what would make a difference for treatment for mental health conditions in prison.

**MS JONES:** The first thing is that the PBS must follow you into prison. For us that is an imperative. Most people are not. Certainly in Victoria Justice Health takes over, which means that carefully titrated medication falls off at that point. It may well have been given in the community, it may well be somebody is medicated. It disintegrates - - -

**MS ABRAMSON:** But that's about the medications. We heard from the pharmacy - - -

**MS JONES:** Yes, so it's really quite daunting how many people have their medication removed the second they go into prison. Unless you can provide the evidence of what they were on prior to admission, it then takes quite some time to then get them back on medication. Your Methadone program doesn't follow you into prison, which is, again, incredibly serious. A lot of people have been self-medicating for a long time using a variety of substances, and alongside that there are very differing levels of care across every prison, and it can be really hard to work out where you would target, but for us I think if we could increase the number of forensic beds, I think, across the system so we could actually treat people with mental illness and maybe pull them out of being in prisons and stop them becoming the new asylums and maybe turn them back into what they once were, that might be useful.

I think the other thing that we see the most of is the fact that you're discharged with no medication. I don't know how many people have experience of what it's like to be discharged from a prison, but you have the natural housing problem that the rest of the community is facing. You're trying to sort out your Centrelink, you're trying to sort out where you're going to go, how you're going to eat, and somebody has given you a prescription for medication and you have no money. You are set up to fail the second you walk out. So unless we can sort out the in and the out parts, and particularly for those discharged from court directly into the community, because we forget the vast majority are discharged not from the prison but directly from court. They don't even go back into the prison. The prison has got no way to pick them up, so it's how we think about the system, and I think that's a much bigger system overhaul as to how we provide that care, because it's got to have some kind of continuity to it.

**MS ABRAMSON:** As you know, we're looking through the mental health lens, but we

would really welcome a submission from your organisation and pointing us in the direction of some areas where you think we should have a look at program et cetera.

**MS JONES:** I'd be very happy to share all of our inside access programs as well that operate in Dame Phyllis Frost and Ravenhall prisons and the work we're doing in there.

**PROF KING:** Harvey, did you have any questions?

**PROF WHITEFORD:** My question was about the relationship with Legal Aid and how you interface different, but you've explained that.

**PROF KING:** Can I just ask one final one on the advance statement? So from another inquiry dealing with end of life and advanced care directives, which obviously are clinical statements, but one of the issues that we found was simply they were ignored, clinicians didn't even realised they existed until it was too late, so even though these were meant to centre the care around what the consumer wanted - - -

**MS JONES:** Yes.

**PROF KING:** - - - in practice it didn't happen, and so I'd be very interested in your advance statement. Do you find that's a problem?

**MS JONES:** How do you make it work?

**PROF KING:** Have you solved that problem?

**MS JONES:** What we did when we launched the advance statements project was we did a joint education system, so as we went in and delivered them we educated all of the practitioners we were working with, and you have to keep that really current. The same applies to the nurses. You can't launch a service and just go, 'Okay, well, we'll just run it and it will just keep delivering.' We have a 96 per cent uptake with the nurses. The reason that we have such a high uptake is because we go in every two months and they know the team. They can ring and talk to any of us.

We did the same when we launched advance statements. The reason we will have a presence in Thomas Embling Hospital, the reason that we still have a presence down at Saltwater Clinic is because we worked with the teams that are there, so it's that embedded tri-focus across the consumer, the team, how we evaluate and how we communicate. You can't write an advance statement in isolation.

**PROF KING:** Yes.

**MS JONES:** You have to have those conversations with your client, and you have to encourage your client to talk to the team. But what's lovely is when the team get the client to come to you as the lawyer and the don't see you as a threat. That to me is the perfect symbiosis, and the advance statement is put with all the legal paperwork for mental health tribunal hearings in the file, which means it's easier to find, as a general rule, I think, than the advance care directives are, which I think tend to get buried in the file, not put in the legal



section, which is more common in a mental health file.

**MS ABRAMSON:** Ms Jones, we would like to have another discussion with you and I've asked the staff if they could talk to you about that. Thank you very much.

**PROF KING:** Thank you very much for that.

**MS JONES:** Thank you very much for your time.

**PROF KING:** Next, if I could ask Dr John Bellavance to come down. Dr Bellavance, if you could state your name, organisational affiliation for the transcript and any opening comments you'd like to make.

**DR BELLAVANCE:** Okay. My name is Dr John Bellavance. I have a PhD in values education from the Faculty of Education at Monash University. My expertise is in the moral use of information and communication technology by young people, and the impact of ICTs or technologies on their wellbeing. I'm the founder of cybervalues.org and I've been writing and teaching values education for 30 years.

I teach ICT in a Melbourne high school and I'm also the Australian vice president of the Universal Peace Federation, which is an NGO in general consultative status with the Economic and Social Council of the United Nations.

So thank you for having me today, and what I would like to argue today is that without values education in younger children or in childhood productivity and wellbeing in schools and in the workplace will always fall short. Hence, the social economic benefits of values education is what I'm going to argue.

As a high school teacher of 19 years, I've come to understand the challenges that students face with respect to their personal development and their social engagement with others, challenges associated with their own attitudes on their own antisocial behaviours. Helping young people meet these challenges is critical for their mental health and their ability to be successful in the workplace and in their relationships. I've come to know that many young people desperately need values education. Of course, the primary source of values are parents and the extended family. However, as a teacher, I've seen first-hand a lack of values in our students. This is shown in a lack of respect towards their teachers and others. It is shown in the lack of control with respect to their behaviours at school and their lack of accountability with respect to their own inappropriate behaviours, the lack of self-control with respect to their uses of ICT and the lack of managing themselves in their personal sense of responsibility with respect to their own learning.

In this situation we have today, parents will often side with their children, even if the child does not take responsibility and sometimes blame the teachers for the failings of their children. But on the other hand, parents also increasingly expect schools to foster values. The outcome of this is that our children lack a sense of responsibility for their own actions and their outcomes, they often feel entitled to what they have, entitled for what they want and a lack of resilience when life does not go the way they want.

These problems are now manifested in the workplace and many examples of issues of resilience in the workplace. This is where the social and economic benefits of values education stand out. After all, all employers want individuals with a strong sense of responsibility that are reliable, resilient and have emotional intelligence. But where and when are these values and these abilities fostered? How can they be fostered is the crucial question.

The second outcome of lack of values education is the struggle that young people encounter when they're confronted with their own personal limitations as young adults. They struggle with little to fall back on when it comes to values and that allow people to be resilient. This then leads to mental health and relationship issues.

So why do we need values education, personal development and relationships education; there is five reasons.

First there is a need for a proactive to deal with mental issues and low self-esteem with a lack of values meaning in purpose in the lives of many people. Second is the need to foster a moral identity of the individual as a good and successful person. Third is the need to address the deficiency in private and public values. Four is the challenge faced by families and fifth is a need to empower individuals. I will talk to you today about the first two points.

As we know in Australia one in five people experience anxiety, depression, substance abuse; one in four young people are at risk of mental illness and so on. Some psychologists maintain that one third of patients who seek help from mental health professionals present with the issue of lack of meaning in their lives rather than chronic anxiety or depression. We need a proactive mental health education; namely values, personal development, relationship developments, since it clearly points to the importance of values, purpose, human responsibility and human relationships all of which provide meaning and wellbeing.

So the question finding meaning is very important to mental health and it's very important for resilience. One of the key elements of mental wellbeing is the right mindset; viewing oneself empowered to be responsible for one's own destiny and to become self-actualised. This requires fostering values, self-reflection, self-regulation, critical evaluation of one's behaviours. A self-actualised person knows their values and their purpose.

Another aspect of mental health is understanding that happiness cannot be pursued. It is ensued from how we live our lives. I teach this to my students all the time. Nobody owes you anything, life does not owe you happiness. Happiness is as a result of your actions, the actualisation of a potential meaning and purpose in our lives. One must have a reason to be happy and once found one becomes happy.

The fundamental issue of being human is the need to find purpose and meaning in our lives to be self-actualised. This is critical for mental health. Most of our time and energy is spent on developing our careers and making money, although these are necessary this can be lead to the pursuit of happiness that is external often ignoring the internal values and abilities that allow us to develop ourselves individually in our relationship.

For many this self-focused and external pursuit of happiness can be unfulfilling. Also many people often search for the meaning and happiness and pleasure fulfilling immediate gratification yet now allowing them to find meaning and happiness. I argue and some psychologists argue that such widespread phenomena as depression, aggression, addiction, are not understandable unless we recognise the vacuum of meaning in the lives of people. So therefore another proactive mental health education as we all know is this fostering self-esteem but what is self-esteem? How do I feel good about myself? I feel good about myself the way I live my life.

Self-esteem is an important aspect of personal wellbeing and happiness. Low self-esteem is one factor associated with depression. Self-esteem also ensues from how we live our lives based on the values and purposes we actualise. Young people are encouraged to develop in Australia many identities; sports identities, performing arts, academic identities, but we need to also foster a moral identity which means that being a good person is an important part of my value.

I will conclude my remarks about the challenges that we face as a society with respect to values education. What is needed is knowledge of the values and abilities that allow individuals to be good and to be happy. Schools tried to do this from various degrees but often have limited our time allocated to pursue this. Additionally, teachers and parents often lack the training and values education so I conclude that mental health relies in part on a holistic approach so I suggest that we need a holistic approach in Australia that a broad - you know, a holistic framework for values education and over the last 20 years I've seen as governments change, one that the flavours and the changes in this which actually does not promote consistency so it's either not included or it's changed and so on so we need to have a bit of a longer view of how this can be done and it can be done.

(Indistinct words) doesn't matter which governments come in, if a framework is broad enough and clear enough it can be done. The values and abilities that underpin, for example, more and effective practices allow young people to face the challenges they face. I raised four sons and it doesn't mean they didn't have their struggles, we all have our struggles. If we're honest each of us faced many challenges in life but how we cope with them depends very much on who we are and what our values are and we need an understanding of the values that also drive antisocial behaviour because that affects their mental health.

The young people that I see struggle with their antisocial behaviour, we seem them struggle with who they are and their identity later on and they will carry that in their workplace and we know this, we all know this because we all work in a workplace and we can judge very easily, you know, who has issues and who does not.

**PROF KING:** Can I ask - sorry.

**MR BELLAVANCE:** I'm almost done.

**PROF KING:** Please, (indistinct).

**MR BELLAVANCE:** So basically as a teacher I'll conclude I found several challenges. First is resources exist right now in the values education sphere that particular aspects of

values some person (indistinct words) relationships but there's not a comprehensive framework that exists at the moment that we can use. Second, schools try to address values and personal development the best they can but there is often little time left to seek to teach the content of an already crowded curriculum. And third, we need a consistent approach which I talked about a little bit earlier.

Such a holistic approach in conclusion is relies basically on six pillars. The three that are probably found in every values education curriculum, the first three is that we need to manage ourselves well; our relationship with others well such as family, peer and community; and our relationship with our physical and natural environment well which includes our home, our neighbourhood and our natural world. These life goals rely on values and abilities associated with the next three pillars which is basically the three moral and psychological domains of reasoning, emotion and behaviour.

Within those six pillars it is possible to develop a framework that is holistic. I'm happy to assist the government implementing this and I will have a curriculum written within those six pillars by March 2020. Thanks for your attention. I'll take some questions.

**PROF KING:** Thank you for that. One of the things that we found in our consultations with value-based education, with value-based programs, with broader social and emotional wellbeing programs; two things that I'd like you to comment on. The first is the school principals found that they were overwhelmed with different programs, that they had many programs being put to them to teach resilience, to teach values for students, to teach wellbeing from all sorts of different perspectives so that the principals found themselves often just flooded with these programs, unable to decide, 'Well, which one's better than any other?'

The second is that talking to many people who had developed these programs, they all had good reasons why their program was better than everyone else's program but again the problem was they all came from slightly different perspectives and ended up creating quite a flooded and confused market so your perspectives on that, that you're developing a curriculum; why wouldn't a school principal see your curriculum and just go, 'Oh, just another one' and how should we actually think about helping the schools to determine which programs are needed?

**MR BELLAVANCE:** Yes, what you said I agree with you 100 per cent. Yes, it would be easily perceived just as another program so therefore I think what needs to be done is to take a broad approach to this. I'm not - in my framework I'm not going into immense detail but I think a holistic approach is needed and so therefore it would be easier for teachers, because teachers don't want to read an entire volume of why - you know, what are the characteristics of emotion - there is many different ways of approaching things and it becomes quite lengthy but they want to see a bigger, broader approach so you need a framework that's simple and broad enough and then they can tease that out themselves.

So without that kind of framework, and I would suggest that we need a values education summit in Australia. Get the best people together and get them to sit together, and it's going to be process - trust me, all these people do have very strong views because I've interacted with many of them - it's not going to be easy but just because it's not easy doesn't mean it's

not worthwhile. But I would suggest honestly to this Commission is we need a values education summit and it will have an impact on productivity for the next 20-30 years, I honestly believe that.

**PROF KING:** Okay, second point before I pass off to my colleagues, is there would be some schools who would say, 'But we have a values education' in particular, and I don't want to pick on particular school sectors, but of the private schools which educate a significant number of students many of them would say, 'Well, the underpinnings are the reason why we are a private school and my parents choose our school' is that we have a values-based education and values are viewed through our curriculum so I guess my question is twofold.

Firstly, are those institutions falling short in your view? Are they incorrect when they're saying they've got a values-based education? And if not, so if they do have that values-based education, we should be seeing systematic differences between the performance of students coming out of those schools than other schools and I'm not sure I've seen any of those to suggest that so those two questions.

**MR BELLAVANCE:** Yes. I guess whenever you teach values (indistinct words) you can't go wrong and if you ask me my opinion whether it's an independent school or religious school whatever you can't go wrong and the schools develop their frameworks and it's very, very critical. It has an impact, I've seen it. However, there's two challenges there. One is that teachers will often complain to, I'm the head of faculty, will complain - - -

**PROF KING:** Look, John. We have a crowded curriculum - - -

**MR BELLAVANCE:** - - - the fact you want us to do more now, they're supposed to do more. There's a lot of pressure put on schools, teachers particularly the ones that are in the cold front, you know, in the classroom so that challenge is that - I'm not quite sure how to address that now, it's a bigger discussion to be perfectly honest but that's one challenge.

And the other one is that we need to train teachers in that space and you might say, 'Well, yes, some schools do' and some of the schools probably do but it has to be consistently done and it has to be implemented well and I'll be honest with you, even the schools that I've seen that have very good values education curriculums still have challenges which means we're not there yet if I can say now it's a bigger discussion but I still feel honestly we can do better in that space.

**MS ABRAMSON:** Thank you. I'm interested in your comments around values because we've certainly seen, and this is not a personal view, it's just an observation, that the whole idea of values is very, very fraught in the public space in terms of public education. As Stephen said when parents may for an independent school they have a view says, 'This is how we teach' but every time we have a discussion about values in a public space it's a very difficult conversation so I'm just interested that you've probably been leading the way on this; how have you got to the position where there is 'an agreed set of values', it's very contestable?

**MR BELLAVANCE:** Yes, extremely so. The minute you say what values (indistinct words) my PhD that's the first question you have to address, 'Who's values?', it's a legitimate question. In the 1970s when values education was introduced it was basically let the kids

decide their values, it was a warm and fuzzy approach. To be quite honest I don't think it worked all that well. Certainly empowering young people, and I argue that in my PhD, to find their value and discuss them is critical but there is a society - we are a society, we're an extended family if you want, and there are certain values that we can stand for that are not dogmatic, not, you know, with agendas and so on, they're our universal values and, I mean, if you start with (indistinct words) declaration of human rights there are some very critical values they don't consider universal, it doesn't mean everybody agrees with them. No one's every going to agree on anything 100 per cent when it comes to values but the attempt of the discussion, the dialogue, and so on is still very critical. And there are universal values. If you want, I can give you a submission on what I think those are but I think that they're a - anyway, yes.

**MS ABRAMSON:** No, I'm more interested I guess in the public space. As I've said before when parents make an election about the education of their child in an independent school they've got a view the schools are quite express, 'This what we teach too' but there's so much public debate around 'the values' so your views on that in a public system would be interesting.

**MR BELLAVANCE:** Well, I taught in the public system and private system so I can tell you both and both of them try their best. Teachers are great teachers whether they're in the private or public. To be really perfectly honest the public sector - a private sector has an advantage because (indistinct words) resource but the challenges to values education are the same. Look, it's true; parents will pick a school I think because they look at the ethos of the school and think, 'My children will get a good set of values' and that's, you know, good on them, that's important to them. I'm not really sure if I understand your question but - - -

**MS ABRAMSON:** Well, I understand your link is that the teaching of values is a critical part of the social and emotional wellbeing of young people, I understand that, that's the link and my underlying proposition was when we have a public - and this is not view, I'm just putting it to you - when we have a public conversation about values it's a very difficult fraught, 'Who's values?' so that's all I was saying.

**MR BELLAVANCE:** The answer to that is that if you sit with a room of parents and you ask them, 'What values do you want our kids' - to be honest with you 89 per cent are shared. It's the same when we come in - we live in a multicultural society which is amazing in Australia, right, and in the UN Interfaith, I'll give you an example, is an important part of UN's work because religions go to war but when you really look at the fundamentals of religion actually some studies show that they have about 80 per cent shared values so, wow, if religions can agree on shared values then people who are not religious can also agree on shared values so I think it's a conversation that can be had and I think it's really noble. I don't see - you won't have agreement everywhere but you can expect that.

**MS ABRAMSON:** Okay, thank you.

**MR BELLAVANCE:** Yes, you're welcome.

**PROF KING:** Thanks very much.

**MR BELLAVANCE:** Thanks for the time, I think I went over my time, sorry.

**PROF KING:** No, no, no.

**MS ABRAMSON:** No, no, we're doing well.

**PROF KING:** Next people, Bridget Hogan and Dr Jennifer Bibb if you could come down front, thank you. And again if you're able to state your names, your organisation that you represent for the transcript and then make any opening statements that you'd like to make.

**MS BIBB:** My name is Dr Jennifer Bibb. I'm representing the Australian Music Therapy Association and I'm their mental health advisor.

**MS HOGAN:** My name is Bridgit Hogan and I'm the executive officer for the Australia Music Therapy Association or 'AMTA' and we're here representing AMTA today which is the peak industry body for the music therapy profession in Australia and Jen I will be doing, if it's okay, a joint opening statement.

**PROF KING:** Please.

**MS HOGAN:** There are over 600 registered music therapists with the Australian Music Therapy Association otherwise referred to as 'registered music therapists' or 'RMTs' and they work primarily in the disability aged care and mental health sectors but we also have RMTs who work in paediatrics, oncology, palliative care, neurorehabilitation, and they provide services in hospitals, community settings, residential care facilities and schools. Now, recognising that music therapy is one of the smaller and lesser known allied health professions and sometimes a little bit difficult to conceptualise.

I just thought I'd take a moment to talk a little bit about what a registered music therapist does. As mentioned music therapy is an allied health profession and AMTA is a member organisation of Allied Health Professions Australia. RMTs have advanced knowledge in contemporary psychological theories, research and aetiology and how music engagement activates neurological structures and human behaviour.

We use evidence-based and targeted music therapy techniques to influence behaviour, improve cognition and communication and develop emotional awareness and competence and some examples of some of the techniques that we use mother include structured or unstructured improvisation, song writing, lyric analysis, play list compilation, therapeutic singing techniques and music assisted counselling, active and receptive music engagement, to name a few. These complex music therapy techniques are underpinned by research as well as fundamental principles in traditional talking therapy like humanism, psychodynamic and psychotherapeutic practice and cognitive behavioural therapy.

Like our allied health colleagues both registered and self-regulated, music therapists registered with AMTA must complete a training course accredited by AMTA which currently is a two year's master's degree. They must adhere to AMTA's code of conduct and practice standards and they must participate in compulsory and rigorous professional development programs. AMTA also meets regulatory requirements aligned with the national alliance for

self-regulating health professions to which it has recently submitted an application to ensure its governance framework is equivalent to its registered allied health colleagues and to increase consumer confidence in the same and ethical practice of RMTs.

Today we would like to provide feedback for the Commission to further consider and hopefully include in its final recommendations around reorienting health services to consumers particularly with regard to MBS-related psychological therapy. If it included we believe our comments will enhance reforms for health care access that is more consumer driven, equitable and effective in meeting the needs of people living with a mental illness. I'd now like to hand over to Dr Bibb.

**DR BIBB:** Regarding the report's premise of creating a people orientated system. The report states that in order to make the mental health system more consumer driven and people oriented, governments should remove the barriers to accessing mental health care including addressing service gaps, lack of coordination and workforce shortages. Despite this acknowledgement of the importance of consumer driven treatment and addressing service gaps, there is no mention within the report of addressing the major gap that is limited access to diverse evidence-based treatment options within the current mental health system.

Traditional psychotherapeutic and psychopharmaceutic treatments are effective for many consumers but these traditional approaches fail to work for a number of people and for them there is substantial need for additional forms of treatment and therapy that can more effectively support them. For example, people who have been impacted by the trauma and challenges of mental illness throughout their lives often like the emotional vocabulary to participate in traditional talking therapies. In this case they may choose to engage in music therapy or other creative-based therapies that provide the non-textual language to gain emotional literacy.

Research shows that for some consumers such as these music therapy will dominate or be preferred over other psychological-based treatment options including those which are currently available within our mental health system. This means that if music therapy continues not to be funded (indistinct) the government is funding a lower value treatment which is a serious issue of inequity. Music therapy is an evidence-based therapy which has substantial support for its use in mental health treatment. Systematic and Cochrane reviews report significant effects of music therapy for people with mental illness in reducing the symptoms and improving quality of life for people with high and low prevalence mental illness and in increasing the outcomes of other therapies when used adjunct.

Despite these published and known benefits of music therapy there is still limited access available to these people most in need of music therapy through the existing mental health system. If the Commission truly were dedicated to creating a people oriented system that is holistic and comprehensive the proposed system would acknowledge the diversity in consumer needs and offer an expanded range of evidence-based treatment options.

Research by key scholars in the field of mental health shows that pathways to recovery are individual and diverse. Within a consumer driven model of care consumers should be entitled to choose treatment options that suit their individual needs. As included in the AMTA's submission to the Productivity Commission a recent benefit cost analysis conducted



by health economists concluded that if music therapy were to be included in government funded schemes that already offer therapy sessions provided by allied health professionals, there would be little to no cost to taxpayers in return for significant results for consumers who choose music therapy as their preferred treatment.

Given the strong evidence-base for music therapy to provide symptomatic relief for people living with mental illness, we recommend that the mental health fund music therapy provided by registered music therapists in order to fill an existing service gap and provide equitable access to a cost effective and often consumer preferred treatment option in particular in regards to the Stepped Care Model and the MBS funded Better Access scheme.

Currently RMTs work with people from the (indistinct) of mental health services, as articulated in the report, both people with mild and moderate symptoms who are receiving treatment by their GP and/or via the MBS and people requiring specialist treatment and hospitalisation. Consumers are already choosing to access music therapy as part of their treatment which reflects client need and advocacy on a local level for diverse approaches to recovery. However, the majority of these consumers who choose to access music therapy as part of their treatment pay for it out of pocket.

Many of the major hospitals in Australia do employ RMTs as part of their allied health treatment team. So people requiring hospitalisation can sometimes access music therapy for free during their inpatient stay however for people with mild to moderate symptoms and those in the missing middle they must pay out of pocket. This is a major concern since the majority of people accessing mental health services in Australia are from low socioeconomic backgrounds and are unable to afford to pay for private therapy.

We acknowledge and agree with the Commission's statements that a Better Access scheme should: be aimed primarily towards people with moderate to high intensity needs who stand to gain the most from face to face psychological therapy; should be rigorously evaluated to ensure it is delivering cost effective benefits to those who need it; and that it is currently inflexible. However, we argue that without expanding the range of professionals who can deliver (indistinct) psychological strategies to include other allied health professionals such as RMTs, the program cannot be cost effective when these therapies are often the preferred choice for consumers.

The program will remain inflexible if it continues to restrict the range of professionals who deliver psychological strategies to only OT, social work, psychology and nursing. This range does not reflect the number of allied health professionals qualified to provide evidence-based strategies and approaches that may be prioritised or needed by consumers. This exclusion creates an unnecessary barrier to accessing other evidence-based strategies like music therapy and it's not non-congruent with the Commission's approach to prioritise consumer needs and priorities in their recommendations to create a people oriented system.

Accordingly we request that an additional draft recommendation is added within part 2 stating: 'Changes should be made to the MBS rules to expand the range of professionals eligible to provide focused psychological strategies such as music therapy'. We'd be keen to discuss this further today but firstly we'd like to thank you again for giving us the opportunity to provide feedback and to contribute to this once in a generation opportunity to work

collaboratively towards achieving a lasting mental health system that supports Australia's most vulnerable people.

**PROF KING:** Okay, thank you.

**DR BIBB:** Thank you.

**PROF KING:** I'll start off really on that last point which is relating to not just the MBS funding but also how consumers become aware of the different therapies and music therapy is one of a number of evidence-based therapies, for example, there's upper mind and body-type therapies that have evidence-based behind them. Where do you see the gateway for consumers to receive these therapies because I can imagine a consumer goes to a GP, says, 'Look, I'm getting anxious' or 'I've got particular symptoms', the GP says, 'Ah, excellent. I'll refer you off in the right direction and maybe a mental health care plan' - we've got an information request out there on that - but should the GP then be saying, 'Oh, well here are your choices, your ten choices of different therapies' at that stage and if the answer is 'yes' how do we avoid the consumer just simply saying, 'Well, I don't know that's why I'm asking you' and so would GPs be the ones who are the guides for consumers or an alternative would be to say, 'Right, well you enter a Better Access scheme', for the want of giving its current name, and there's a dialogue that occurs with whichever professional is providing the face to face therapy under Better Access and that dialogue then leads to the decision by the consumer, 'Well, actually I'd like to use some of my sessions for music therapy' and again if so how do the incentives play out in that system where obviously you have a person who has, the clinician in that case, has an incentive to keep professions with them because any system is going to have some sort of cap on the number of sessions and that's just reality of government and taxpayer funding so I'd be very keen - even if the recommendation that you want, even if we put it in there, we then need to say how will this be implemented, I guess that's what I'm getting at. So my question to you is how would that be implemented on the ground to actually enable that consumer choice?

**DR BIBB:** Yes, absolutely, and we recognise that that is the next step and so we see it happening via referral from the GP and so, you know, also acknowledging that we'd need to provide education to GPs around what music therapy is and why a referral might be appropriate in different cases for consumers, you know, particularly for a consumer who's unable to kind of process things through traditional talking therapies we'd recommend a referral that way or if they were already engaging in music for mood regulation and anxiety management and things like that in terms of the training and where it would go from there we recognise that, you know, we'd need to provide some education for GPs at that level.

**PROF KING:** Do you think that education is enough? I mean, one of the comments that has put to us is that we are in a system under Medicare or ten minute medicine for GPs; do you think that the GP would be able to get enough information, and remembering we want the consumer evaluating the choice here, enough information in a ten minute session with a patient or the consumer to be able to give the consumer the right choices so the consumer can make the decision as to the referral pathway, that seems a lot to ten minutes.

**MS HOGAN:** Yes, and I think the responsibility falls on the profession to not only educate the GPs and the referral sources but also to consumer groups and the consumers and roll out

our own campaigns to raise awareness of music therapy just not to health care professionals but to consumers. I don't think that's one of a GP's greatest challenges with the amount of allied - not just allied health services but the many services that could be available for consumers to access is to know how to point them in the right direction and how to guide the consumer bearing in mind that the consumer really must be participating in that conversation so I think the onus falls on the profession, ourselves, in rolling out an education program for both consumers and for the referral sources. I'm not sure if that's what you were getting at.

**PROF KING:** Yes, I'd be interested further if you plan to put in a further submission I'd be very interested in getting more details around that because I still have trouble seeing how that would work under our current system and one of the issues that we're grappling with is, even if we think of some consumers coming in and face to face therapy or music therapy is appropriate for them, but for other consumers actually moderated online, group therapy, some of the other therapies mentioned earlier today, the GP is trying to do all of that within the timeframe; so make clinical judgements and then provide advice to the consumer we're having trouble at the moment seeing exactly how that would work with even a more limited range of options, once you start expanding the options it seems to start making - you risk actually having the situation where GPs say, 'Well, this is the easiest. Here's a referral, go off there' and we get worried about that because that takes away consumer choice.

**DR BIBB:** Yes, it does. But hopefully that's not the reason to restrict eligible therapies or eligible disciplines or professions because it's going to be too difficult for a GP to (indistinct words), yes we need to work on it, a system that can empower the GPs to have that knowledge or to access that knowledge and to communicate and share that with the consumer. Yes, that is one of the challenges.

**PROF KING:** Or as I said, you know, is there an alternative gateway? It may be that you have a 50 minute session with an allied health professional who can then, you know, (indistinct words) Better Access session who can then present the alternative pathways once they've got to know more about the consumer, but anyway rather than brainstorming here I'll pass over to my colleagues.

**MS ABRAMSON:** I just wanted to ask one question and bearing in mind time pressures I'm happy to have it on notice I'm hoping you'll put in a further submission, it's around working with young children and we heard yesterday from two professors about how very, very early in life mental illness can become diagnosable, for want of a better word, so I'm really interested in your submission fleshing out where music therapy works in that space because I've made an assumption actually that with kids who are not verbal that actually music therapy could be a very important part of therapy and also within schools because within the school model it's a different funding mechanism so just really interested and happy to take it on notice.

**DR BIBB:** Yes, so we can certainly provide some research and things regarding children who are non-verbal and the work that - because RMTs are working with children in that space in Australia. In terms of in schools and in terms of early intervention and prevention we have had some research where we've had some programs funded by the ARC for music therapists to go into schools and work with wellness kind of welfare counsellors and those kinds of people within the schools to provide education around healthy and unhealthy 'eaters

of music' which is a term that we use in music therapy to kind of describe how music can be both a really great tool for healthy coping and coping with emotions for young people but also acknowledging the negatives that using music can bring because we know that four young people who have trouble regulating their emotions and perhaps have a mental illness, we know through research that they often can use music in ways that's not helpful and that actually reinforces negative thinking patterns and behaviours that they're already engaging in.

So this program went into some schools with children at risk and used this kind of - their HUMS program to look at how we change the student's ways of using music so that they're more aware of the music that they're listening to, and how it can actually promote their mental health, rather than - and you know, be a resource for them going forward, in future. And that showed really positive results for the students.

**MS ABRAMSON:** And a formal evaluation.

**MS HOGAN:** Correct, yes.

**MS ABRAMSON:** We'd be very interested in seeing that.

**DR BIBB:** Yes, I can certainly pass on the references for that.

**MS ABRAMSON:** Yes, thank you very much.

**PROF KING:** Thank you.

**PROF WHITEFORD:** So I guess my comment would be similar. I don't know if you've seen what's called in the code, this IAR document, which is the primary healthcare network guidance document that the Commonwealth has produced? It's worth looking at because what it tries to do is give guidance to GPs about where on the stepped-care model, patients, clients who they see, can be referred; there is no mention of music therapy in the document, which I'm sure comes as a great shock to you.

But the challenge is, what the other commissioners have raised is, what information will be needed to guide that? There is over a million people - which you probably know - go through their access system, a lot of people. And most of them come through primary care and go through GPs, get a mental healthcare plan; and in that, the GP has to make a call about whether to prescribe medication, refer to a psychologist, social worker, occupational therapy or psychiatrist.

And if you could look at the document, just look at the domains which are proposed in the document, and just give some thought to what would have to be added to provide the sort of information in front of the GP which would assist in thinking more broadly about options that the consumer might choose.

**MS HOGAN:** Yes, and I'd link this to a conversation we had with the MBS taskforce when we submitted a very similar submission with regards to their mental health reference group; and a lot of the questions are, "Well, what is a trigger for music therapy?" And you know, a GP, "Well, when? Who would I refer to music therapy, and when would I refer to that?"

And that question can be asked of each step in the stepped care model, and we certainly need to - the education program needs to be very much about what are those triggers for music therapy for mild or complex illnesses? And the cohort that might be best suited to music therapy. But we would definitely also refer to that document.

**PROF WHITEFORD:** Which is on the Department of Health website.

**DR BIBB:** Yes, okay.

**PROF KING:** All right, thank you very much.

**MS ABRAMSON:** Thank you very much.

**DR BIBB:** All right, thank you.

**PROF KING:** Now, I think Debra Scott is the next person. Ms Scott, if you could just state your name and your representative body for the transcript, and then any opening comments you'd like to make.

**MS SCOTT:** Thank you. My name is Debra Scott and I am presenting myself, as an individual. I might mention here very quickly, it was actually a talk that I had with someone, so I've sort of come not fully prepared.

As an individual, where I will start, I was initially a carer of mental health services, short-lived, and I am now a user of mental health services. I am a user of mental health services in relation to a topic that's been touched on today: I became a survivor of loss by suicide. And the reason I am wanting to talk is picking up on listening here today - one thing that I found that these two topics, for me, they're interrelated - is the barrier of stigma that I felt was a double whammy.

And when I talk about this, I'm not going to disclose anything too personal about being a survivor, because I am still working through it. But what I found was I framed the nature of what occurred in my family behind a wall of the silence of stigma to protect myself, at a time when I didn't even have any mental health condition.

If I backtrack: as a carer, I had gone through it with a family member; it was the pre-2014 Act. I was studying - I'm a social worker - and I was studying mental health at the time and finishing my masters. I am fully aware of the changes in the 2014 Mental Health Act. And I recall a question was raised earlier around advocacy, and had I have had that when this adverse event occurred to me, I would've had more leeway.

But being a critical social worker - and I use the word "critical" - for me, there is a difference - I'm stepping into professional and then I'll move into personal. The critical social worker is one that works within a system for people who have marginalised voices, from oppressive things like I'm talking about: stigma, the shame of speaking out. I had a crisis situation where I was at a hospital, dealing with what was happening, and I said, "I don't need cards. I

need to have a support in place with you until I can work out what's happening here, in my family."

My social work role was, I am faced with going home, I have no community support, I have no family. My daughter at the time was living overseas, it was just me and the other family member. The reason I raise this is because if this had happened to me after the Mental Health Act, when I was in the hospital setting saying, "I can't do this. I need one night to sort this out. I need some support because I am dealing."

The other reason I raise it - and I think it's been touched today - I went to the Royal Mental Health Commission; a key thing I learned - because I've been researching since this happened to me, being a social worker and wanting to go back to study one day. A key thing to me is how - it's identified in the report - lived experience; it's very valuable because we can inform - I say "we"; to me it's a community, that's what I felt when I went to the forum. It was a safe space, I could disclose what I wanted to, with other people.

A key thing I took away from that setting, there was a variety of societal issues affecting people; could be eating disorders, sexual abuse. There was a range of issues, but we shared a common identity on the day. Many family members were prone to some sort of mental health themselves as a result of their family member. A key thing there for me was how we work with services to get the lived experience.

What is missing? Access to services, pathways when you've got a crisis. And I will move on from here. And I found in that setting, sharing our experiences of a system, knowing that the royal commission is listening to our voices and we're working together to solve an issue.

But for me, one of the key things - and I'd sort of like to really raise this - so prior to this, I am operating in a situation of societal/structural situation; the nature of my death is rare in the context of normal and abnormal deaths. So one, I have a rare - I learned this through my research. The second thing I learned was when I spoke to one person - I forgot to bring an equation: this person's death was also work-related, so I had a legal context, so I'm dealing with two additional layers.

Not only when later on - because my mental health didn't start initially then, it was sometime later - so not only was I dealing with a rare nature of death, something that is stigmatised - perhaps not by me, but by some societal views. The way I context that is historically, some people see it as selfish, some people see it as sinful, some see it as a crime; or perhaps, some people, it's not talked about.

Even today I'm quite anxious, and I'll share that, but I'm controlling myself. And that's what happens; it's not a conversation that you start up and say, "Oh, what happened?" That happened. Stark wall of silence and I think to myself, "Okay, I'm not going to mention that." So I create a secret environment. The thing that I was unprepared for when I went to a doctor, as I think I just recently then - when I initially went as a carer, there was a - the person could've got a mental health plan; I said, "We don't have time for a mental health plan. I am a social worker; we need to be linked into a service." "That will cost extra."

"I'm not worried about the money and the bigger question; this person has a crisis. We need to push the boundaries." That happened the next day: supports were put in place with work, so this person could go on; so supports were there. What I learned for myself - and I don't mean to be jumping, and I've got limited time - what I learned for myself was sometime later when I actually reached a crisis point; I decided that I had a choice: I could stay behind the silent wall of stigma; I could live in fear of speaking out.

Where I had learned to speak out was at support groups, people like myself. Because we were too scared to speak out to other people. Very valuable.

**PROF WHITEFORD:** Can I just ask a question?

**MS SCOTT:** Yes.

**PROF WHITEFORD:** Sorry to interrupt. So just what would've made a difference at the time for you; how could the system have been different to make it easier for you to speak out, and not feel behind that wall?

**MS SCOTT:** The system. If I can come to the workplace, perhaps? It would've been nice for the workplace - because I'm pre-2014 - it would've been nice for someone to say to me, "Wow, that's really tough, what you're dealing with." We don't have a lot of supports available at the moment.

**PROF WHITEFORD:** In the workplace?

**MS SCOTT:** In the workplace, or even at the GP; we don't have a lot of stuff available. But what would you need? In answer to your question, what would've been helpful? Empathy.

**PROF WHITEFORD:** From?

**MS SCOTT:** I hid it from my workplace because I needed to work until I could sort it out. The only empathy I got was from my university, because I thought, "If I'm a social worker and I can't use my experience when I'm ready to begin to make a - am I answering you?"

**PROF WHITEFORD:** Yes.

**MS SCOTT:** So I think it was having someone actually say to me, "The support I'm going to give you is a bit of flexibility. I'm going to cut you some slack at university. This is what you need to do." Is that making sense? So I had those supports in; it eased-off that pressure.

And I guess the thing I found is, given the context and the nature of the death, until my own research, grief and loss - societal structure tends people to just operate within that grief and loss theory, it doesn't have the additional layer, if I'm making sense? So people you're working with expect you to get well, "This is what grief and loss is, it's non-linear, but you need to be moving on." Am I making sense?

**PROF WHITEFORD:** I think the thing is, I know there are probably many areas, but if you had to just highlight a couple - you've just done one for us - through your experience, are

there areas where you could make recommendations that we could consider that would've made it different for you, made it better for you?

**MS SCOTT:** Okay. Even if I go back, there was an ED clinic; a recommendation could've been there. It was when I was talking to the mental health nurse, airing my opinions. If someone had have said, "We don't have a bed. This person doesn't meet the high-risk criteria," what would've been helpful then if someone had had said to me, "Do you have any other supports? Do not leave this person alone," rather than saying to me, "Oh, it's fine now. We've ticked-off the boxes, the person is fine."

**PROF WHITEFORD:** Yes.

**MS SCOTT:** Or even I guess, picking up on other people talking about information and knowledge; if I had have known what I know now, if that's making sense? If I had the education and the knowledge. So for example, at the doctor the next day, or even the ED: if someone had have explained to me what situational depression is, I could've Googled it and known not to leave that person; if someone had have explained to me, instead of giving me two cards and ring up. I wonder if I've answered your question? Key.

**PROF WHITEFORD:** So we've got only a couple - - -

**MS SCOTT:** Yes, I know.

**PROF WHITEFORD:** But if you had to give us one other one that would've made a difference for you, what would the next one be?

**MS SCOTT:** If there is a way that we can destigmatise I guess what it's like for us being left behind - I say us - and also, break down the walls of mental health, to break it down so if someone is breakable, reach out, because the cost of not reaching out is far greater than not.

And the final thing, if I am able to, picking up on the therapy; my daughter is a dancer and that's what we're wanting to do, is now use dance as a platform. But touching on the other people talking with art therapy; there is not much research out there, because we're looking at intervention. And that's where we're at, and we're hoping to use that because recent research over the last year and a half is showing that there is benefit in dance, music, art therapy. I went to a recent veterans' safe talk - because people can sometimes communicate through non-words. But it is only an additional resource. So thank you.

**MS ABRAMSON:** Thank you so much.

**PROF WHITEFORD:** Thank you very much.

**PROF KING:** Thank you very much, yes.

**MS SCOTT:** Any other questions?

**MS ABRAMSON:** No, no. Thank you.



**PROF KING:** Can you just see if there anyone else at this stage?

**MS ABRAMSON:** I think we really wanted one at a time.

**PROF KING:** In that case, I will adjourn for lunch. Yes, so if we recommence by 1.30; let's say that. So thank you.

## **LUNCHEON ADJOURNMENT**

### **RESUMED**

**PROF KING:** I'll reconvene after lunch the mental health hearings. I will actually grab back that bit of paper you gave me and then I gave back to you. Thank you. Just a reminder for anybody who's joined us at lunch time, these are the public hearings into our draft report, the Productivity Commission's draft report on the inquiry into improving mental health in Australia. The hearings are being streamed live via the Commission's YouTube site. All participants who have registered here at this hearing have confirmed their understanding that they may be visible or audible online. If anyone here has queries about this or does not wish to be visible or audible online please approach one of our inquiry team members here today or feel free to leave the hearing now.

Participants are not required to take an oath but should be truthful in their remarks. Participants are welcome to comment on issues raised in other submissions. I also asked 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 and use the visitors' room next to the disabled toilets. If at any time you feel distressed please approach one of our staff who will assist you. We also have with us Bronwyn Williams who is available to provide psychological support. You can tell we're into the fourth session of the two days when the Commissioner is starting to have trouble pronouncing names.

In the unlikely event of an emergency requiring evacuation of this building, the exits are located in the hallway between here and the lifts. Upon hearing the evacuation tone please leave the building and assemble at the grassed area across Bligh Street unless given an alternative assembly location by the fire wardens. Please put mobile phones on silent and if I could ask Dr Astha Tomar, please come down the front. Thank you.

**DR TOMAR:** Any chair?

**PROF KING:** Yes, any chair. And, Dr Tomar, if you could state your name and affiliation for the transcript and then if you have any opening comments you'd like to make.

**DR TOMAR:** Sounds good. So my name is Astha, Dr Astha Tomar, I'm representing the college - Royal Australian and New Zealand College of Psychiatrists the Victorian Branch. I'm the deputy chair of the Victorian Branch. And I have a little summary prepared if that's

okay I'll just go through it.

**PROF KING:** Yes.

**DR TOMAR:** Yes. So thank you to the Commissioners for giving me the opportunity to address you today and provide comments and feedback on the recently published Productivity Commission draft report.

Firstly, I would like to acknowledge the Wurundjeri people, the traditional owners on whose land we meet today and pay my respects to their Elders both past, present and emerging.

As I said my name is Astha Tomar, and I'm the deputy chair of the Victorian Branch of the Royal Australian and New Zealand College of Psychiatrists. The college is the principal organisation representing the medical speciality of psychiatry in Australia and New Zealand. It is responsible for training, educating and representing psychiatrists on policy issues. The college has more than 6600 members including more than 4900 qualified psychiatrists and over 1500 associate trainee members.

The Victorian branch of the college has around 1500 members including more than 1100 qualified psychiatrists and around 400 members who are training to qualify as psychiatrists. As mental health specialists psychiatrists are well positioned to provide constructive input into improving the delivery of the mental health services.

We see this inquiry as a once in a generation opportunity to critically evaluate and influence definitive reform of the mental health sector. This inquiry is a chance to increase focus on prevention and early intervention while ensuring a rehabilitative and recovery focus within the mental health services with the overall goal of increasing the cost effectiveness alongside improving the consumer outcomes.

In April 2019 the college made a submission to the Productivity Commission inquiry into mental health. The college's consultation process highlighted the realities of a complex, fragmented and under-funded mental health system which is failing to meet the needs of the most vulnerable members of our community.

The recommendations contained in our submission were based on extensive consultation with the college members from a range of faculties, sections and expert committees. It is clear that improving the mental health of Australians requires investment beyond the mental health sector to ensure all Australians have equal opportunity for good mental health regardless of their individual circumstances.

From the Victorian branch perspective we believe that the focus needs to be placed on the most chronic needs of the system and we argue that investment is needed right now to address under funding, under resourcing and undervaluing of Victoria's mental health system.

As part of this it is important that certain areas of need are addressed by the Productivity Commission, and we advocate for the government action around the following six key priorities: the first one being the governance, accountability and funding to establish a sustainable system. We at Victorian branch RANZP are supportive of the rebuild model as

mentioned in the draft report which aims at clarity and funding and responsibilities. Establishment of an authority like Regional Commissioning Authority, or RCAs, would help in providing continuity of services and minimising gaps in the service provisions.

In addition to that we would also like to highlight the need for mechanisms which need to be put in place to ensure that the funding which is allocated to mental health is spent on mental health. Mental health receives parity of funding with physical help. Funding is commensurate with current need and re-actable increased needs. Increased funding equates to improved consumer outcomes and the funding needs to be linked to the workforce strategies, and the (indistinct) of the psychiatrists and people with lived experiences are imbedded as leaders throughout the mental health services to ensure the structures and system create safe, high quality care for consumers and continuous improvement activities are undertaken.

The second key point is that there has to be an addressing of the psychiatry workforce shortage and improving the training pipeline. Now, amongst the OECD - Australia is below the OECD averages for psychiatrists per capita and the situation is forecast to worsen. We need more funding to increase the number of trainees and strategies to make psychiatry a more attractive option. We need to do better in retaining our public psychiatrists. The reason for psychiatrists leaving the public sector are multi-factorial, yet it can also simply be attributed to the excessive demands being placed on them in an under resourced sector.

We have to ensure that there are sufficient inpatient beds to meet the demand. The increased bed base has to be done so there are 50 beds available for 100,000 population. There should be a range of beds available including acute beds, sub-acute beds, intensive care beds and beds in secure extended care units. All major public acute psychiatry units in Victoria continually operate at 95 per cent capacity, which is well above the desirable levels of 80 to 85 per cent. These capacity constraints mean the psychiatrists currently have no choice as to which unit they admit the consumers to. Consumers of different ages, genders and symptoms are currently being admitted together which creates an unsafe environment for both consumers as well as staff. Appropriate gender and age specific wards need to be available at every service to ensure that the people are provided an appropriate option upon admission.

As mentioned in your draft there is a need for more dedicated child and adolescent mental health awareness. There's also been a mention of the missing middle, and that's our fourth point, that we have to establish out-patient centres for the mental health to address the missing middle.

We would recommend that the public outpatient clinics are re-established in Victoria to provide psychiatry treatment to the missing middle. These could access a mix of state and federal funding. These clinics could take a variety of forms from being imbedded in the hospital outpatients to integrated community mental health hubs which could include integrated drug and alcohol services, employment services, social welfare services, psychological supports and psychiatric services. We have also advocated for integrating the alcohol and other drug and mental health services to provide better continuity of care.

And the last point is increasing services to address the demographic changes. The ones that we have highlighted are the CALD, communities, that is the culturally and linguistically

diverse population, as well as the aged population, and increasingly aging population. As stated in Victoria's 10 year mental health plan services must address language and cultural values as these can hinder effective treatment and support, migrants of all status as a result from culturally and linguistically diverse backgrounds should be able to access culturally appropriate services in a language they can understand.

The Victorian branch advocates for the needs of culturally and linguistically diverse communities to be considered when the services are being established and areas of additional needs should receive a commensurate increase in funding. The number of Victorians aged 65 and over is said to treble by 2058. The aging population will result in increased demand for services for older people as well as with longstanding mental illnesses are joined by others with mental illnesses which develop for the first time later in life.

The Victorian branch has advocated to the Victorian Government for the development of a mental health plan for older people which takes into account the future demand and resources. It also identifies service delivery priorities. So those are the key priorities we wish to highlight in our submission I put today.

**PROF KING:** Thank you very much. I'll start at the other end. Hervey, would you like to - - -

**PROF WHITEFORD:** Thanks Stephen. So the issue of workforce, you've recommended increase in training positions.

**DR TOMAR:** Yes.

**PROF WHITEFORD:** Obviously for those training positions to be accredited by the college we need supervisors.

**DR TOMAR:** Definitely.

**PROF WHITEFORD:** Is there any recommendations that you might have or suggestions about how we can get more psychiatrists to provide that supervision which will accredit those - make those places able to be accredited as training places for the college?

**DR TOMAR:** I think for now the psychiatrists who are working in public hospitals where most of the trainees are working in your clinical work everybody sort of gets squashed in, so unless there is a time set aside for a psychiatrist to be able to provide supervision it's sort of becomes like it's on the go and it adds to that pressure, so one of the main things is that there has to be a recognition for the work - for the supervision work which is being provided by a consultant psychiatrist. There has to be recognition for it and there has to be a - you know, time set aside for it. It can be done but it can't be done when a psychiatrist is busy doing 20,000 other things which they are supposed to be doing.

**PROF WHITEFORD:** And so it's about having quarantine time for the supervision?

**DR TOMAR:** Yes.

**PROF WHITEFORD:** The second issue about training is that there are some concerns that we've heard about the training of psychiatrists including from trainees - - -

**DR TOMAR:** Definitely.

**PROF WHITEFORD:** - - -that a lot of the training is in acute public hospitals.

**DR TOMAR:** Yes.

**PROF WHITEFORD:** And a lot of psychiatry is as you were saying is not inpatient psychiatry and - - -

**DR TOMAR:** True.

**PROF WHITEFORD:** - - -so trainees become skilled perhaps at the sort of case mix that might be seen in an acute public hospital inpatient unit but receive less training in broader areas of mental health treatment.

**DR TOMAR:** Sure.

**PROF WHITEFORD:** Is there anything we can do to, if you accept that that's the case, is there anything we can do to help overcome that?

**DR TOMAR:** I think that would - there are two aspects to it: the first is the need for training and provision of the psychologically minded therapies, psychologically therapies in the public hospital. Now, the college has highlighted that there is a need for trainees when they've finished their training that they have to be more skilled in psycho-therapy but they don't really get that opportunity when they're training in a public hospital but that's mainly because if you look at the public hospital the services which are being provided they are acute in nature, so either they're being provided as crisis assessments and management plans in EDs or in the inpatient units.

So as far rotations go for a trainee they do end up having very limited trainee - limited rotation options, so unless the - you know, if and when there is a service provision for, apart from the acute services, the other services that are being provided, the trainees will have an opportunity to have training in those positions, but otherwise there has to be sub-specialities and super-specialty training positions which are quite scarce. For a trainee to finish their training they have to have a child adolescent rotation and it's next to impossible to get one in the first - you know, during your training, so as basic as something like child adolescent rotation is hard to get by, let alone a drug - you know, drug or alcohol or a psycho-therapy specific training position or a perinatal or an eating disorder. So, you know, we do come out - we finish the training and it's more, as you said, more acute service exposure than others, and we have highlighted the need for specific positions and the health services to provide those opportunities.

**PROF WHITEFORD:** Is it possible to look at where - like, offering training positions in the private sector for example?

**DR TOMAR:** Some hospitals do do that, some training programs do do that, but some hospitals, especially if they're not centrally located and they have anyway such a shortage of trainees it's not on the priority then because it becomes the trainees - they end up providing more - you know, the provision of the health service and their training, the focus of shifts when they're working in a hospital which is a pity but, yes, so there are some training programs which would offer those positions and then the trainees get attracted towards those programs but then semi-rural or regional areas are not able to provide that and they lose their trainees and they have a shortage of trainees. They have a shortage of psychiatrists, so it sort of feeds into each other.

**PROF WHITEFORD:** Thank you.

**PROF KING:** Couple of questions, you mentioned CALD services, culturally and linguistically - - -

**DR TOMAR:** Linguistically.

**PROF KING:** - - -diverse communities. And I think everyone recognises the need to have services that are, you know in relevant languages particularly if it involves therapy that are culturally sensitive. The question then comes up how they're actually done, how they're put in place, how do they work? Have you got any thoughts about that?

**DR TOMAR:** I think the first is just the recognition of the need for the same, and initial bit is the option of having an interpreter available and not using family members as interpreters, and also being aware of cultural aspects to a person's presentation as well as their acceptance of the treatment which is being provided. So one is the awareness which if we look at our training programs we do sort of focus a lot on it because initially it used to be a biocycle social model and now we're talking about it as a biocycle social cultural outlook towards whether it's the assessment and the management or the treatments being offered. But within a health service, within a psychiatric unit or the health service providing those options or awareness of that is still at the really (indistinct) stages. It's not there but it is an ever growing population group and the needs are quite different and they need to be acknowledged, recognised and catered for but I think the first step is just the recognition of it.

**PROF KING:** You said psychiatric training does include issues of relating to culture and diagnosis, so do you think that's adequate at the moment or is there more work that needs to be done?

**DR TOMAR:** Definitely.

**PROF KING:** I'm aware - as an outsider I'm aware that, you know, some presentations do depend on cultural background, that different cultural groups - - -

**DR TOMAR:** True.

**PROF KING:** - - -with the same underlying mental illness can present very differently.

**DR TOMAR:** Well, initially we need to be aware of it. Initially we are expected to read

about the articles and be able to sort of write up something on it, but when it comes down to hands on getting your hands dirty with an experience, it just happens along the way, so the opportunity only arises whilst you're working in a system, so, you know, the - when the curriculum is there, it's a part of the curriculum. When you're examined, it's a part of that examination process, but when it comes down to actually doing it, it's more what you learn along the way and the team you are with or the supervisor you are with, so it's sort of a lot depends on - it's almost like stroke of luck. Like, I the sense, getting an experience. If you had good experience as a part of a good supervisor, then you'd be more capable of doing - you know, handling those cases, but otherwise people are on a bit of a back foot around how to do those assessments and what to be aware of and what to offer.

**PROF KING:** So any suggestions about how to improve that, then? If you need to take that on notice - - -

**DR TOMAR:** Yes, I think for now what we are sort of suggesting, especially in Victorian government pre-budget submission we done the same thing, that we - that the funding to a service, there has to be a bit allocated - has to be set aside in an area which has more (indistinct) communities and then work on it.

**PROF KING:** Just the other area, and sort of again touches on the difference between the public psychiatrist's role and the private role. We've heard about the lack of or the shortage of public psychiatrists, but it's also been suggested that that is different to other medical specialisations because of the way private psychiatrists get remunerated but there's too little incentive for them to take on new patients but it's - I won't look towards Harvey, but it's much easier to operate as a private psychiatrist and much more lucrative than being in the public system, which we don't tend to see in other medical specialities or there are other offsetting positive benefits of being in the public system. So is there anything that we should be thinking about in terms of recommendations to the government in changing the way the private psychiatrists are remunerated in order to be able to help get around that shortage in the public systems?

**DR TOMAR:** I think the remuneration part is a bit to it, but I think more is the satisfaction you get as a professional in a private setting and I work in both, so I can sort of talk from a personal opinion as well as what we've been talking of the (indistinct). Where at a private level you do feel like you're achieving a lot more in terms of direct contact with the patient. You're able to do more of psychotherapy but in a public hospital your role just becomes like - it's more crisis-driven, so you're sort of just setting - you know, not setting fires. Putting out the fires.

**PROF KING:** Putting fire out, yes. Extinguishing fires.

**DR TOMAR:** Extinguishing the fires. Putting out the fires. In a public hospital, a doctor's role becomes quite limited. It becomes very narrow and I think that - and again, in a public setting the role is expected that of being a leader. But if you look at it, the role does become very much clinical oriented where you come and do your assessment and go away. So it just becomes very narrow and you feel quite undermined of what you can achieve, but you feel very limited with what is available there to be able to achieve that. So I think a lot of people end up in private mainly because the satisfaction of what you can achieve and what you can

push out is a lot more.

**PROF KING:** Yes.

**DR TOMAR:** So it's not just the remuneration. It's the kind of work, the quality of work you do, so you end up doing more of quantity of work and less of quality of work. So the expectation from the carer, from the family, from the community is that you have to provide that bio-cycle social cultural model. But the way you're remunerated or the hours you have, you would be having one session and you're supposed to look after whatever, 80 people on your board and you end up just doing a biological bit, so it's a pity but - so as a psychiatrist what you can offer doesn't happen in a public setting. It happens in a private setting.

**PROF KING:** Okay. Thank you very much.

**DR TOMAR:** Thank you.

**PROF KING:** Next, Steve Michelson. Again, if you wouldn't mind saying your name, the organisation and any initial comments that you'd like to make.

**MR MICHELSON:** Thanks very much, Commissioner. My name is Steve Michelson, I'm the spokesperson for Australians for Mental Health, and we really thank the Commission for allowing me to make a few remarks on behalf of AFMH today.

So just by way of background on Australians for Mental Health, we are a not for profit organisation that seeks to make mental health a national clinical priority so that together we can achieve once in a generation change on how we support 4 million Australians and their families who have been touched by mental ill health every year.

We like to think of ourselves as a people's movement guided by experts that is fighting to fix Australia's broken mental health system. We are proudly passionate about being a voice for those with a lived experience and working with the system and alongside the system and the sector to achieve improvements. We're governed by an independent board of directors that include experts and people with - and carer experiences including Sopana Bisim, John Brogden and Pat McGorry, and we also have patrons including Maggie Beer, Jessica Rowe and Allan Fels.

We are funded through a combination of philanthropic and crowd sourcing resources. We do not accept any money from governments of any political persuasion to ensure that we are able to help hold politicians to account, and we do believe that generations of politicians have failed Australians living with mental health issues over several generations.

So really what A for MH is about is to build a campaign that forces Australians to act, a little bit like the 'Every Australian Counts' campaign that led to the establishment of the NDIS and other social issues of late, including the way in which domestic violence was swept out from under the carpet.

We absolutely welcomed the draft report of the Productivity Commission and we hope that the myriad of failings that were found, but also the economic cost being between 43 billion



and 51 billion per year, provides an imperative for politicians to act once and for all.

In terms of further observations, we are not surprised by the finding of the draft report in relation to the scale of the problem and the fact that this has been underestimated by successive governments - territory, state and federal - for many years. We believe, therefore, and as stated, that successive governments of all political persuasions have failed Australians living with mental ill health.

Most OECD countries spend between 12 and 16 per cent of their health budget on mental health services. However, Australia spends only around 7 per cent, despite the burden of disease being around 14 per cent.

The economic cost of mental illness, as found by the Productivity Commission, we believe pales when compared to the human cost borne by those Australians routinely failed by the flawed system. We support the findings around the need to scale up prevention and early intervention services and the need to engage young people at the earliest possible time so as to prevent progression of illness and the development of high-risk and invariable costly crisis situations.

We also support the need for ongoing evidence-based psychological interventions and support for people who have attempted suicide or engaged in self-harm. The Commission's draft finding or draft report's finding revealing that 25 per cent of people who attempted suicide will try again, whereas only 50 per cent of people discharged following a suicide attempt receive follow up treatment is absolutely something that we say must change.

We also support the Productivity Commission's finding for the need for greater investment in services beyond health in order to tackle our mental health crisis. In particular, the needs of Australians with complex mental health conditions extend far beyond the clinical supports, and therefore we urge governments to consider investment in a range of areas including educational, vocational training, housing, physical wellbeing and other supports to ensure that a positive outcome is achieved.

In particular, on behalf of A for MH we speak on behalf of carers and families who are often forced to pick up the shortfall of the system which can negatively impact on their own mental wellbeing, careers and education opportunities.

It's our position that there is an overwhelming need for fundamental change to the way mental health services are delivered so that every Australian can access safe, therapeutic mental health care when they need it for as long as they need it, and therefore we support the draft report's finding around the need for reform in the following areas, being access to care and support, quality of care, improved prevention and early intervention services, clear pathways to care, improved support and services for families and carers, improved monitoring of physical health, improved and targeted specialist services and the need to end discrimination.

I just wanted to particularly highlight and support the draft report's observations around the missing middle, and in particular to applaud both the current coalition government but more recently Labor Opposition for endorsing on a bipartisan basis the establishment of the pilot

program to establish the adult mental health community hubs in the last budget to the tune of \$114.5 million, and in particular this investment was to support the establishment of eight trial mental health centres to deliver a range of free specialised mental health support services for adults requiring treatment, including treatment after hours, because our members, and in particular their families, like my own, have often found a system that's very complex, that's hard to engage with, and that obviously then has a number of negative impacts.

But as outlined in the last federal budgets, the adult mental health community centres will provide wall in coordinated care and advice for anyone with mental health concerns and will address what is seen by many as the missing gap in the mental health system.

The centres will be rolled out in eight yet-to-be-determined locations nationally, but ultimately, and per our advocacy to the federal government at the time, we would actually love to see one adult mental health community hub in each federal electorate across the country, being 151.

If implemented correctly, we believe that this pilot program may serve as a model for a future larger investment of public funds in critical mental health services. But in order to be successful, we believe that these centres must truly offer services that are unique but also that are combined, including service navigation support, specialist psychiatric care, psychological services, social and community support services, drug and alcohol counselling, 24/7 assertive outreach, consulting rooms, visiting specialists, facilities for GPs and allied health professionals and online and telephone hotline services.

We would also love for these services over time to consider other means of support around people with mental illness and their diets or alternative forms of treatment so that we move away from trends around over-medication.

So in conclusion, we thank again the Productivity Commission for its work and for the draft report, and we believe that it does underline the need for urgent action and structural reform that we will continue to demand of governments from all levels. We believe that the Productivity Commission inquiry is a unique opportunity to transform the way in which Australia cares for those members of our communities and their families who are touched by mental ill health, and we thank the Productivity Commission for this invitation to speak and attend the public hearing, and for the opportunity to present our case for change.

**PROF KING:** Thank you. Clearly the community centres is a key issue from your organisation's perspective, but perhaps moving forward, albeit slower than you would prefer. You also mentioned just in passing scaling up prevention and early intervention services. Particularly in that area, in the prevention and early intervention, or any other areas, what specific actions would you like us to recommend to government that we haven't covered off so far? So we recognise the community centres isn't something we've gone into detail with, but are there other areas where you say, 'Look, we think you should have recommended this. This is what we want the government to do.'?

**MR MICHELSON:** I think one thing that perhaps could be recommended that's not currently in there is the need to provide the inpatient units in early intervention mental health services but specifically for young people. So this goes to, I think, an observation that the

report makes around the way in which as a country and as a nation we have traditionally sought to treat mental health through the prism of the way in which we treat physical health, and so we believe that we're still really at the first base, if you like, in terms of actually providing enough beds and support for people with mental ill health, but given the prevalence of mental health issues amongst young people, we would love to see some of those inpatient units and early intervention supports budgeted for by governments, and so we think that a recommendation from the Commission would provide a great platform for that to happen.

**MS ABRAMSON:** All right. Thank you, Mr Michelson, for coming along today. I want to ask you about consumer and carer participation. We've heard a lot from other people who've made submissions to the inquiry, and also about the relational aspect of recovery. But one of the things that we're really interested in is that there seem to be different understandings of what the terminology is, so I'm really interested. What does consumer and carer participation look like from where you sit?

**MR MICHELSON:** We believe that consumer and carer participation really has to go to the implementation of what we hope is significant investment from government following inquiring, including that of the Productivity Commission, but also we know, say, here in Victoria there is the Royal Commission into Mental Health, which we hope will lead to some recommendations and, following that, investment. But it's not as if there hasn't been significant investment by governments over time. We say obviously and predictably that it's not enough. We would like it to be equal in fact to the way in which government invests to physical health, but we have to make sure that we don't throw good money after bad, and so we would strongly advocate, and to your question, that people with a lived experience, consumers of the system, people who care for those who are participating in the system, actually sit at the table and have a hand in the design of reform and to help decide how it is that, you know, future investment is made, and I think further to that we would say that, you know, often for our members it's about the coal face. It's about being in that time of crisis, you know, and having a resource that people can contact easily in order to seek the assistance and advice that they need instead of having to go through a long, convoluted process, often meeting dead ends.

And so therefore we don't want to see just an investment of several millions and millions and millions of dollars made without due consideration to what happens at the coal face and in real time in people's lives.

**MS ABRAMSON:** Thank you. We've made a number of recommendations sort of along those lines, about how people access services, navigation portals. We would really welcome a further submission from your organisation, bringing that practical focus that you've just talked about. Well, how would that actually work for people who are accessing the service. That would be really helpful.

**MR MICHELSON:** Well, thanks for the invitation and we'd absolutely love to do that.

**MS ABRAMSON:** Thank you.

**MR MICHELSON:** Thank you.

**PROF KING:** So thank you for what you've said. Coming back to the adult mental health hubs, one of the concerns that's been made to us is to ensure that there's no silos within a region receiving mental health services, that there's some planning for regional needs and that the services are all integrated. The relationship of, say, the hubs to other primary care providers run by the PHNs (indistinct) practises, et cetera. How do you see that working so that it not sort of silos within, you know, a regional area?

**MR MICHELSON:** I think it's a great question and I think it goes to the heart of how it is that we make these hubs successful, and I think also we would say that we need to be practical because, for example, if we do advocate, which we are, for there to be one adult mental health community hub in each federal electorate across the country, we know that certain federal electorates have better primary health services as it is versus others, particularly when we think about rural, remote and regional Australia, so I guess we would like to see as much interaction and collaboration between services as possible, but we appreciate that that's very much easier said than done and so for us we think - and perhaps leading to your colleague's earlier question, we think that as much local consultation as possible the better, because ultimately we are going to have to ensure that the hub fits into a local community and in fact capitalises on, you know, existing services, be they primary or secondary, where they exist, and that's also going to be really important to ensure that we extract the most benefit out of what is, you know, in the grand scheme of things, very modest funding, and to ensure that those trial sites are a success, so I'm not sure if that answers your question, but it's tricky.

**PROF KING:** Yes, it is tricky.

**MR MICHELSON:** Yes.

**PROF KING:** So a lot of the regional planning that goes on now is expected to be between the PHN and the state or territory local hospital network.

**MR MICHELSON:** Yes.

**PROF KING:** And we've heard that that depends a lot of personal relationships.

**MR MICHELSON:** Yes.

**PROF KING:** In some places it's working well and in some places it's not working so well. We've been I guess asked to give some attention to what we could put in place to sort of make that more likely to happen that isn't dependent upon personal relationships. One example is the regional commissioning area grouping of resources and pooling of money; that sort of thing, and the criticism of that or the concern about that is that you lose within that some of the specific service elements which have proved to be successful. So I guess anything you can - and obviously you can take it on notice, but anything that the organisation can provide us for how to get that balance right I think would guide us to being able to make the right recommendations.

**MR MICHELSON:** Well, thank you. I might take that on notice and actually provide you with some more information. I think, though, you know, from our perspective, and again

speaking on behalf of, you know, people with lived experience as much as possible as we can have a seat at the table, you know, is really what we ask for, and I appreciate not everyone can have a seat at the table. Of course not. We would love that, but it's not possible. But I think we will take that on notice, but as a general principle we would absolutely urge those localised structures to take on board the voices of people in the local areas with the lived experience.

**PROF KING:** Well, I think our view would be that every area planning mental health services that didn't have lived experience as part of it would be deficient from the outset, so I think that certainly would be our position.

**MR MICHELSON:** Thank you.

**MS ABRAMSON:** Could I ask one more question if I could, please, on stigma reduction?

**MR MICHELSON:** Yes.

**MS ABRAMSON:** And thinking specially about your own background in communications we'd be really interested in your views on that.

**MR MICHELSON:** Look, for Australians for Mental Health we think that the way in which we will truly see action and the way in which we will truly see mental health receive the investment in reform that it deserve is when politicians of all political persuasions understand that without acting they may suffer at the ballot box, and so really for use we believe that now is the time, as illustrated by this inquiry, but also by other historic inquiries like the Royal Commission into Mental Health. You know, we think that the time for mental health to become a national political priority has arrived. We think it's here, and that's absolutely what we are seeking to do and what we are seeking to support.

But the other big part to it is to ensure that decision-makers themselves also are educated and understand the lived experience of people with mental ill health because we know that in the halls of Parliament, whether they be territory, state or federal, across the country, there is still a reluctance and reticence for decision-makers to necessarily engage in this topic as fully as they might so, you know, for us we want to work with the media, we want to work with the institutions of society, both those within the mental health sector but also with corporate Australia, to try and break down those barriers and we absolutely support and love the observations and recommendations in the draft report that go to early intervention in schools. We think that's absolutely where this all starts, so we really do welcome that.

I think one other observation I'd make is that there is in Australians for Mental Health's eyes a need for us to differentiate between awareness campaigns and action, because we know that there are lots of organisations out there in the sector who do great work when it comes to awareness campaigns, and that's critical in providing support for people with lived experience, and we also know that government from time to time invests in awareness campaigns. But if we are truly going to, you know, break down the stigma, which is getting in the way of a lot of the reform that we would like to see, we do believe that we have to make sure that an awareness campaign, another awareness campaign, funded by government, is not seen to solve these problems. That, for us, would be selling ourselves incredibly short.

**MS ABRAMSON:** Thank you so much.

**PROF KING:** Thank you very much.

**MR MICHELSON:** Thank you.

**PROF KING:** Now, our next speaker is stuck in traffic. Normally I'd do this a bit later on, but is there anyone else from the floor who hasn't registered to provide evidence before the Commission today who would like to present evidence? If not, I will - then let's take a short break. Let's try for 2.30, hopefully, not 3.30.

**MS ABRAMSON:** Sorry, 2.30.

**PROF KING:** Let's just take a break for perhaps 12 minutes and hopefully the traffic will have eased up by then.

**MS ABRAMSON:** There's tea and coffee.

**PROF KING:** Outside. Thanks.

**MS ABRAMSON:** Thank you.

## **SHORT ADJOURNMENT**

**PROF KING:** If you'd be able to state your name, the organisation you're representing for the transcript and then if you have any opening comments.

**DR PRING:** Yes, thank you. My name is Bill Pring and I'm the media spokesperson for the Independent Private Psychiatrists Group, and in my opening comments I'd just like to congratulate the Commission on what you've done so far with the draft report. Very comprehensive, covering a large number of very important points which we've identified.

We'd, though, like to be able to work with you further because we believe we've got quite a lot of good information to provide you for fine tuning the report that you'll finally produce, and I'd have to say we're certainly very inspired also by our patients that we treat. We work very closely with Jan McMahon of the National Network of Private Sector Mental Health Consumers and Carers and we work quite closely together, and I feel that our whole sector, both our consumers and carers, and the practitioner seems to be ignored somewhat in past inquiries that have occurred, so that I think it's quite important because our sector treats the seriously ill people in our community to a similar level as the public sector.

So we see about half of all the seriously ill people who are in our Australian community and therefore we think that's a pretty important sector not to ignore because we do recognise that it's important to look at the milder end of the spectrum where smaller amounts of input can achieve a lot of productivity gains in the workforce and so forth, but in the more serious end

of the spectrum, that's where suicide is more likely to occur, that's where there are bigger problems being able to work and so if you can treat people properly, that's the other thing that we feel is being ignored a little bit, not particularly by your Commission, but in other inquiries, but expert treatment needs to be provided to people in order for the social supports that are also vital for people to be useful and for people to recover and for suicide to be prevented.

I think that our sector has been ignored sometimes I think because even politicians have said, 'We treat the worried well,' meaning people that perhaps shouldn't be being treated and that we only treat the rich. But in fact we've done a lot of research on that over the last 15 to 20 years and we've got outcome measures, the HoNOS outcome measure, looking at the people that when we put them into hospital and they have a similar severity rating as people going into the public sector psychiatric hospitals, and so we think that the idea that we're just treating the worried well is quite wrong, and we have also done a survey that has shown that 45 per cent of the people we treat in the community are unemployed, and we know first hand there are people that will sacrifice an awful amount financially in order to be able to maintain private hospital insurance, for instance, and be able to achieve private care, and so they're not rich people. Twenty per cent on that survey of our patients are also receiving government pensions.

So we'd like to work with you to try and further enhance what is already an excellent start on looking at the productivity side of mental health.

**PROF KING:** Thank you. Just on the data issue that you mentioned there.

**DR PRING:** Yes, yes.

**PROF KING:** I'll look back towards where some of our people who deal with empirics are chatting to each other at the back. Do we have co-payment information for private psychiatrists? Sorry, it's just when you were talking I thought that was the answer and I thought, 'Ah, we actually do have a data gap understanding -' because obviously we have data about the number of billings and services and so on going through MBS but of course there's co-payment issues. You said that you'd done the survey where you'd looked at the severity level of a sample of patients of private psychiatrists, and you'd looked at you said 20 per cent of patients were receiving a government pension.

I mean, one of the issues that you would be well and truly aware of, and you said in your opening statement, 'Ah well, we're only treating the rich.' But of course data on the actual size of co-payments under the MBS, how they're spread, how many are bulk-billed versus non-bulk-billed; that sort of information is very hard to come by, and I was wondering does your organisation collect anything like that? Have you done surveys on anything like that that you'd be able to provide us?

**DR PRING:** Yes, no - - -

**PROF KING:** It's really filling a data gap from our perspective.

**DR PRING:** We're not highly funded, but I think that - I think actually the data on co-

payment is available under Medicare. I think actually it's like an averaged data, so it's looking across the whole lot. I guess that Medicare statisticians would be able to find the cohorts of people that may pay different gaps in data that's not publicly available, but I think that there is no doubt that there are significant gap payments being charged and we address that quite strongly in our main submission to you, and it actually applies across the board, really, with specialists other than GPs. Even the GPs I think we may find in the next find the gaps will increase, and it's not ideal because people - even some of my own patients where we do discount a lot of people. Maybe not back to the rebate, but back to the schedule fee, which is the government-approved fee, sometimes a little more, depending on people's circumstances.

If we didn't do that, if we didn't charge a co-payment we wouldn't be able to practise in a reasonable way and our - without going into a lot of detail now, our submission shows you how the fees that most of the psychiatrists as charging above the schedule fee now are quite reasonable if you look at CPI increases from the relative value study that was done in 1995, which was never formally completed but nevertheless there was a lot of data was known about what a fair fee for a doctor's service would be.

Then if you apply CPI increases which have not been applied in Medicare, you would find that the total fees that psychiatrists are charging are quite reasonable according to that sort of criterion, but unfortunately Medicare rebates haven't kept up, and I think that's actually going to be a rather big issue not just in mental health, but in a sense mental health consumers are like the canaries in the coal mine I think because they tend not - in the serious end of the spectrum, they tend not to be able to attract or be able to work consistently enough to obtain very high incomes, and so I think you may find that the mental health consumers are the first to be concerned more about the gap payments and the fact that - but I think all people across the spectrum soon will be complaining about gap payments.

**PROF KING:** And I think you are right; I think there is some data there because I can remember seeing it for one other clinical group. Thank you for your response there. Harvey, would you like to - - -

**PROF WHITEFORD:** The question came up earlier about training of psychiatrists, one of the issues that we've identified is there's the lack of psychiatrist numbers, especially some of the sub-special areas like child and adolescent and older age psychiatry, and the training that is heavily dependent on the public hospital system.

**DR PRING:** Yes.

**PROF WHITEFORD:** Is there any comment you could give us about how we could increase the number of training positions in the private sector?

**DR PRING:** I'm not quite sure - I can't, in a sense, speak for the whole sector and generally I have been involved in a lot of training over my time, just me personally and a number of people in our group as well. I think we've done most of that training voluntarily and still do, and I think that's quite a good system in a way, but if you were trying to get more training happening, you would probably have to put some funding into it, and I think that the - I'm actually, and our group is, a little concerned that with the high medical gaps and the emphasis



which is reasonable up to a certain point of having more consultation work from private psychiatrists means that we may be training even the modern psychiatrists out of the longer term care which we as a group feel is very important in terms of preventing suicide and allowing people to recover to the extent they possibly can.

Just as a - I'll de-identify, but there's a case of mine just recently who I saw this young man when he was 17 and he had his first episode of schizophrenia, and he has had one psychiatric hospitalisation since then. He's now the age of 45 and he has had one psychiatric hospitalisation to change him over to Clozapine electively, and that's the only psychiatric hospitalisation he's had. His GP was excellent and saw him initially, started treatment, I saw him. He's been able to continue working in his work at the time, which was in hospitality, up until the present time when a physical illness stopped him from working, and in private work we see a lot of cases like that, and it both inspires us and encourages us to get that story out into the community because that's what I think should be happening for all people in the community. Some sort of care like that. I see that person once a month and by doing so I've been able to prevent relapses and that sort of thing, and it's a very effective way of treating people.

**PROF WHITEFORD:** Thank you. The other question was about private health insurance and there's been some concerns raised about that. Did you have any issues on that that you specifically wanted to raise with us?

**DR PRING:** Yes, and again, they're addressed quite robustly in our original submission. We are very concerned about private health insurance. We're finding more and more difficulties with what we call unwritten rules that limit our ability to treat people adequately at times, and so we are concerned, and again, robustly, in our addressing of that, we feel that probably the private health insurance system is not sustainable really, I suspect, and we need to look at other systems which we've discussed this in our submission. We need to look at systems like medical savings account systems, like in Singapore, or whole of life insurance policies. Any change to the private health insurance system would have to be introduced over 25 years, over a generation probably, but it might be worth doing, just like setting up a superannuation system was a very good idea when that was set up.

May I also just say that it sounds like I'm talking just about private psychiatrists in the community, but in fact we do work with lots of other health professionals and mental health professionals in the community. I think that's not often recognised as well because we're not in institutional teams. We're not meeting twice a week. People think that there are no teams in the private sector in the community, but in fact we find who are good psychologists to work with, who are good GPs to work with, where we do not have to take the whole load of looking after the person adequately and therefore we don't have to see the patient as frequently and we can manage to see other people as well, and I don't think that system is actually recognised, and that's also discussed to some extent in our original submission, and I think that's a very important point; that we're not working on our own, and if we wanted to increase the number of the more serious cases that we can treat, then I believe we need a system that helps us all in the community work together even better and there's a suggestion in our paper, but I think it's eminently doable and it would be wonderful to see a system that actually more rapidly dealt with people in those circumstances.

**PROF WHITEFORD:** Yes, because what you're alluding to is what we've heard from other people who put submissions in, that the more you work with the more serious complex needs of consumers and patients, the more a multidisciplinary approach is essential.

**DR PRING:** Well, it varies, you see. I think that case that I presented to you was largely managed by me.

**PROF WHITEFORD:** And the GP.

**DR PRING:** If I could rely - the original GP that referred that person has died, and there are other GPs, but actually I did notice in your submission the idea of further training of general practitioners to be able to perhaps look after the serious end of the spectrum better, and whilst my GP colleagues will criticise me for saying this, I actually agree that that would be very useful because I also personally, for instance, treat a number of doctors, including GPs, and when I ask them, 'How many GPs do you think are really interested in treating people with conditions like yours?' and they say, 'Maybe 5 per cent.' I said, 'What about 10 per cent?' 'No, probably closer to 5 per cent,' and I think GPs could do the job with us and allow us to see more people, use our expertise in that way, and I would love to see something akin to the Meadows model that's been used in Victoria in the public sector but funding wasn't continued. But it could occur in the private sector and through peer review groups of combined GPs, psychologists and psychiatrists, we could actually help increase the expertise in these community teams, and we don't need a huge administrative structure over us if it's cleverly organised through Medicare system and a referral structure of some sort that makes it possible, similar to the one that is illustrated in our main submission.

**PROF WHITEFORD:** Thank you.

**MS ABRAMSON:** I just have one question, Dr Pring. It's regarding regional and rural access, because we know that we have certainly shortages of psychiatrists in certain disciplines, which we've talked about, but in our report we were very concerned about how we can get services to people in rural and regional Australia, so I'm interested in your views on that.

**DR PRING:** Yes, I've got very firm views about that, and our group does too. We've discussed this a lot amongst ourselves. A number of us do telepsychiatry, telehealth. Our consultations almost exclusively are consultation-based service. Interestingly, I've certainly found that many rural GPs have the necessary skills to look after the end of the spectrum that I'm tending to treat and can implement the management plans that we might do through the system of 291 assessments that were set up in 2006. Can do that very effectively and can follow the management plan, so they've sometimes - the GP for me, for instance, has referred people back after three or four years and they're much improved but the GP is wanting to know what the next step is towards recovery for this particular patient. So that's a very satisfying thing both ways.

The other thing is I think the last really good study on the mental health needs of rural and remote populations was done by Burgess, and I think it came out in 2002, maybe. With all of the study, I can't remember now whether the study was actually done in 2002 and it came out later, but in any case, it was around that time, so that's a long time ago now, but to me that

was the last good study into what the actual needs are, and they gave a lot of raw data in their report and I went back and studied that and I won't go into all the details but the bottom line was a lot of the rural patients were being seen to a similar extent as the public sector, so we in the private sector actually, even before we had telepsychiatry we were actually treating people at a similar level, especially if you look at patients actually being psychiatrically assessed as distinct from - and I'm not trying to run down the mental health teams that work in those areas. They're usually very experienced and very good too, like the GPs in those areas. But not everyone gets to see a psychiatrist first-hand, and if you looked at that I think more people were probably seeing private psychiatrists than public psychiatrists.

But all I'm saying really is that we're important in the rural areas too, but one thing I have particularly noticed, and I've been doing the telepsychiatry, I suppose, since it began. I'm not sure when that was, but it's probably at least eight years or so now, and I'm noticing more and more people that I see in the country town that I'm mainly servicing who have moved up from the city. They're usually on pensions, they have multiple medical problems, not just mental health problems, and they're coming to the country because the living expenses are less and actually probably the medical system, until some of these good GPs retire, is reasonably good too, and the hospitals and the mental health nurses and CAT teams and so forth I think are at a very high standard compared to the city.

But they're going there but they're taking with them a lot of comorbidity and I don't think that's really been fully recognised, and I think we're about to hit - we're seeing a lot of crises that the fires and natural disasters are temporarily producing, but I think we're about to see a collapse, actually, of a lot of rural infrastructure, including overall health infrastructure, let alone mental health infrastructure, and just finally I'd just say that the introduction of NDIS seems to have decimated a lot of the mental health supports that were working previously in the country from going - I've been to the Royal Commission hearings, including a couple of ones in the country areas, and it feels to me like a lot of the mental health supports, have actually been supplanted by other cleverer people who are able to get into the NDIS system and we've lost a bit of capacity in that area as well.

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

**PROF KING:** Thank you, Dr Pring.

**DR PRING:** Thanks.

**PROF KING:** You're going to head off?

**PROF WHITEFORD:** Yes.

**PROF KING:** Away, Commissioner Whiteford.

**MS ABRAMSON:** Thanks, Harvey. Are you coming to Sydney?

**PROF WHITEFORD:** See you in Sydney.

**PROF KING:** Just remember: three hours to the airport.

**MS ABRAMSON:** He's got his walking shoes on.

**PROF KING:** Next we have Julian McNally. If you'd be able to state your name and your affiliation for the transcript, then if you have any opening comments you'd like to make.

**MR McNALLY:** Sure. Julian McNally, ACT of Living, and I was simply going to read something I've written because I was given instructions about keeping it brief, so I thought I'll - - -

**PROF KING:** Yes, please do and then we'll ask some questions.

**MR McNALLY:** - - - type it up so I can keep it as concise as possible. So thank you for the opportunity to address the Commission, and of course thank you for undertaking the Commission and a very comprehensive draft report which I haven't read every page of. So I'm a principal psychologist of ACT of Living, which is a private clinic of eight mainly psychologist clinicians in Northcote, and our clients comprise mostly adults referred by GPs and psychiatrists for treatment under Better Access but also include those needing psychological treatment funded by bodies such as NDIS, WorkCover and TAC, and of course people who self-fund.

Since 2014 our practitioners have recorded session by session outcomes using assessment tools provided by the US-based Centre for Clinical Informatics headed by Dr Jeb Brown. The centre's customers comprise behavioural health care organisations, psychiatric hospitals, substance abuse treatment clinics and private practitioners and together they form a network of clinicians known by the acronym ACORN, A Collaborative Outcomes Research Network.

Since 2007, ACORN has delivered over 3 million questionnaires in more than 800,000 cases. The resulting database allows the ACORN tools to predict from a client's initial scores on the questionnaire how quickly they should improve, assuming competent practice, from their clinician.

One of the most important findings from the research the Centre for Clinical Informatics has conducted on these data is that clinicians who simply log into the system, presumably to determine their client's progress, are more effective than those who don't, so in one recent study they've stratified the clinicians according to the level of engagement with the tool. The high engagement clinicians are the ones who check in on the tool most frequently, low engagement rarely at all, and there's a sample of the statistics that you find from that study. A client of one of the high engagement clinicians, in other words someone at the 50th percentile, has a better outcome than about 57 per cent of clients in the low engagement group, so there's a marked difference just from clinicians paying attention to their outcomes.

What you get from that - the benefits - are obviously better outcomes resulting in shorter treatment times, fewer dropouts and greater value per dollar spent, and this is why the insurance companies love it. So our experience with these tools is, you know, if we compare ourselves to the ACORN database, I don't know how many clinicians there are in that, but 800,000 cases, not just hundreds or thousands, and so I like to call those people as a body the average clinician, or at least the average probably largely North American clinician.

So what we've achieved is greater improvement on average per client, longer engagement so an average of five assessments over the period of treatment versus 4.3, a longer treatment period: 12.3 versus 10.6 weeks, and we know longer treatments correlated with either lower dropout rate or more complete treatment.

We have a 50 per cent higher rate of improvement per week, so, you know, that's where we get the better outcomes. It's sort of like we're taking longer but we're getting more improvement each session, and a greater proportion of patients improving so overall improvement, not significant improvement: 73 versus 68 per cent, I think for significant improvement. Ours is about 56 compared to about 48, and by the way, extensive studies have looked at what's the level of improvement that you'd expect in an average population treated by an average clinician. It's about 40 per cent, so even the ACORN clinicians are doing better than average.

We've also got a lower proportion of severely deteriorating clients. Again, 4 per cent, the ACORN average is 6 per cent. Something I include in informed consent with all clients now is, you know, there's a chance that you'll actually get worse by seeing me, but hopefully it's less. By the way, the ACORN level of 6 per cent, I know when I looked at that three years ago it was 7 per cent, so that overall database is improving, and I'll refer in a little while to studies where the sort of standard expectation of deterioration is a bit higher than 6 or 7 per cent.

The other area we want to take this into is segmenting our database of cases so we have about I think it's 750 cases in our database by demographics and broad diagnostic categories so that we can provide a best-fit therapist for each client, so, you know, I have a selection of eight therapists. When I found out who's good at what, we can start getting a good fit between therapist and client, and I think that's important, so rather than base it on, as is usually done in private clinics, it's either the in-take manager's intuition or a particular therapist saying that they're good with a particular client profile, or just that they have an interest. We'd like to see it based on, 'Are you actually any good working with this demographic of client or this diagnostic category?'

So I had a quick look at my results before I came in and apparently I'm much better with anxiety treatment disorders but I'm not the best person to see for depression.

I think the benefits of getting widespread use of outcome questionnaires such as the ACORN tools would accrue to almost all stakeholders involved. Now, this is the sort of explosive statement, so stand back. There would be a global increase in standard of care due to workforce attrition of the least affective practitioners. In other words, if you knew a practitioner was in the bottom 10 or 20 per cent, why would you see them? If the practitioners knew that, maybe they'd actually leave and find a career that they're more suited to.

I'm saying that as a former salesman that was, like, barely average but got by. I'm much happier working as a psychologist and I'm probably I think a little bit better than average.

Outcomes would improve for the majority of practitioners, not just those already using the

tools. I know you've been exposed to the sort of conflagration over the divisive multi-tier system in Medicare. That could actually be retired and replaced by an outcomes-based payment system or at least a rebate system that didn't depend on or wasn't segregated by training, professional affiliation, et cetera.

If we were able to ensure that clinicians linked client diagnostic categories to treatment progress and then published their outcomes across diagnostic categories, it would allow clients and treatment funders to pay for the best available treatment, you know, again, rather than depending on networks.

Deterioration and adverse event rates could be lowered. I see you've had many submissions from carers and consumers distressed by what happens when you go seeking treatment and you actually end up worse, which is not always the practitioner's fault, but, you know, it happens, and if there's a way we can direct it we should.

The research on this is really troubling because without measuring outcomes and deliberately looking for deteriorations, clinicians are actually hopeless at detecting it, so I'm just going to give you some results from a couple of studies. In a sample of 49 psychotherapists, clinicians markedly overestimated their rates of positive client outcomes. They estimated them at 91 per cent, and as I said, the average is about 40 per cent. So generally you go and see a therapist of some kind, 40 per cent of the time you'll get a good outcome, but most therapists seem to think that about 91 per cent of their clients will.

When clinicians in the study were actually told in advance that the population they were seeing had an overall deterioration rate of 8 per cent and were then asked towards the end of the study or after the end of the period of treatment to go through their files and estimate which clients had deteriorated, out of 550 cases they nominated a total of three cases - in other words .5 per cent - as deteriorating, and they'd been told that 8 per cent would. These people are highly trained in statistics, remember. So it seems we're not particularly good at that.

In another study, a sample of 129 therapists in private practise - so the study I just referred to is a variety of counsellors and therapists at university counselling centres. So the average clinician rated him- or herself at the 80th percentile of all therapists. I found this quite humbling. I'm sort of somewhere between 60 and 70 per cent and on a good day towards 80 per cent, but mostly, like I said, I'm a little bit above average but nothing to get a big head about. None of them rated themselves as below average. Remember the statistics training all these people have done.

The typical therapist in the sample estimated the rate of client deterioration in their own caseload to be 3.7 per cent, so about half what you would actually expect. So what I think has happened with the ACORN therapist, and this is something that Jeb Brown has written a couple of research papers on, is that they simply check and pay attention to where the clients are improving. On a not-quite-objective basis, it is the client's self-report, but it's a little bit like we sort of run a mile from a doctor who didn't check your weight, blood pressure, blood sugar levels. So I wonder why we aren't doing this in our field.

**PROF KING:** I think you're talking to the converted. Is it possible to get some of the

references you referred to?

**MR McNALLY:** Sure.

**PROF KING:** The studies and so on. The ACORN outcome monitoring; they're specific measures that ACORN used rather than standard assessment tools?

**MR McNALLY:** Yes, what they've done is taken - I see you referred to Michael Lambert somewhere in one of the recommendations.

**PROF KING:** (Indistinct) 1,280 (indistinct).

**MR McNALLY:** Yes. You haven't read them all.

**MS ABRAMSON:** No, we have read them all.

**MR McNALLY:** He produced an instrument called the OQ45, so it's 45 items, it's been heavily researched and he's probably the leading person in his field of, you know, monitoring outcomes and feedback-informed treatment. Jeb Brown basically condensed that to the - he provides a number of tools, some for adolescents, some for Spanish-speaking people, some for, um, people with alcohol or gambling problems, but the one we use is a kind of general one. It's like a 12 or 13 item distillation of the 45 item one.

So we have no problem having clients complete that. Private practice setting and, you know, they're highly motivated of course, but I think it can be done in other settings and, you know, the other ACORN practitioners are doing it.

**PROF KING:** How do you actually do that as a matter of - is it that it takes some time out of the formal 50 minutes/hour of the session or do you ask them to fill in whilst waiting before the session, or what's the mechanics of that, because that will be an immediate response. Well, you're taking up therapeutic time filling out a form.

**MR McNALLY:** Yes. I've dealt with a number of therapists offering that objection and that was back when I was using a simpler measure that just had four items and you'd just cross somewhere on a line.

**PROF KING:** Yes.

**MR McNALLY:** This is like five-item responses. So we have people who do different things, so sometimes the receptionist hands it to the client when they come in and, again, once they're used to that's part of the procedure, they do it. We provide the rationale for it in the first sessions. I tend to hand it over in the session. It also has three items at the end that the client completes that are basically feedback on the session.

Now, again, I think a lot of therapists say that they ask for feedback. This is a way of actually getting the feedback directly and of course the idea is, you know, if you measure it, pay attention to it. So if you see something is out there - like, I have picked up people sometimes with an alcohol problem that, you know, hadn't been disclosed in the first two

sessions, but then they start saying, 'Someone's worrying about my alcohol consumption.' Or self-harm suddenly crops up, so it does have some assessment value rather than just being a four-item test I measured before. It's just a, 'How are you feeling?' You know, 'How are you functioning socially?' 'How are you functioning individually?' This is a bit more targeted.

It also has these other benefits, so one particular WorkCover case that the insurer was recommending that the person attend less frequently or actually cut off her insurance, I was able to show that when we'd had a previous period with greater gaps between treatment sessions she deteriorated; when we picked them up again she'd improved. It was almost like a field ABA design, and that resulted in the funding being reinstated. So I don't understand why anybody would not want to do it. Sorry, have I answered your question?

**PROF KING:** Yes, you have. That's good. Although, again, just in terms of time is it like five minutes in general or - - -

**MR McNALLY:** It takes about two minutes. You know, two or three minutes.

**PROF KING:** Has there been any work done on the different ways of presenting the outcome measurement to the consumer or the client and whether that has an effect, so I was wondering, you said you passed it across. So if you have the client fill it out in front of you, I wonder if that leads to different outcomes than if they're passing it onto a receptionist or something?

**MR McNALLY:** I can't name anything, but I think something has been done on that. Yes, one of the risks, and I think this is what you're talking about, is that, you know, the client wants to please the therapist.

**PROF KING:** Yes, yes.

**MR McNALLY:** Or if the clinician is working for an agency, the client may be concerned that the boss is going to, you know, grade or performance appraise the clinician based on what they say so they say good things even if, you know, the therapist isn't performing well. But, no, I - - -

**PROF KING:** Don't know if there's been work on that.

**MR McNALLY:** I think some research has been done but I don't know where.

**PROF KING:** Just in terms of actual concrete recommendations, so have I got it right? One recommendation you would like us to make or feel that it would be useful to make is outcome monitoring at every session is part of Better Access?

**MR McNALLY:** Yes, yes.

**PROF KING:** Yes, and again, just making sure we're both - - -

**MR McNALLY:** Yes. No, I think you've got a recommendation in there about, you know, what - or sorry, a request for more information about what should we do to mental health



treatment plans.

**PROF KING:** Yes.

**MR McNALLY:** This is something I provide the data on the GPs when I send my six and 10 session letters. Don't get a lot of feedback from GPs about whether that's useful. I just feel like it's a, you know, very quick way of giving a visual summary of how the patient is going, but, yes, I would definitely like to see everybody doing that.

**PROF KING:** Okay, and the second recommendation that you'd be interested in us making would be that the outcomes data should then be publicly reported and available to consumers and presumably GPs and other professionals; anyone interested, basically. And that should be done on what diagnostic basis?

**MR McNALLY:** Well, probably all. Like, I can't see a disadvantage.

**PROF KING:** There have been issues - putting out public information is, for example, done in England. It's also done in some parts of the US for different specialisations outside of mental health.

**MR McNALLY:** Yes.

**PROF KING:** I don't know of anyone who does it in mental health. The issue becomes the risk rating and the potential for cherry-picking, so, 'Ah, well, I've got two clients both who formally have depression, but one is going to be much easier to treat than the other, so I treat the one who's easier and the other - the one who's harder to treat I say, "Look, I can't see you by -".'

**MR McNALLY:** Yes. Well, I'm in two minds about that because on the one hand I think if we're not good at detecting deterioration maybe we're no good at even making that estimation. On the other hand, I supervise a number of psychologists and, you know, it's quite clear, like, everybody sort of says, 'Oh, I don't want to touch someone with borderline personality disorder,' or 'the more severe eating disorders,' or whatever.

**PROF KING:** Yes.

**MR McNALLY:** I don't know. I think, yes, you can take that either way and perhaps there might be some areas where we say, 'Look, nobody is going to treat borderline personality disorder if they know, you know, the outcomes are so hard or treatment resistant depression,' or whatever.

**PROF KING:** Yes. Well, that's by a diagnostic group. I was actually thinking within diagnostic groups, so within a particular - you know, that's why I picked depression.

**MR McNALLY:** Yes.

**PROF KING:** So you can get your ratings up by dealing with somebody who may have depression - - -

**MR McNALLY:** Okay.

**PROF KING:** - - - but it appears relatively mild, there's no comorbidities and so on versus somebody who has depression but may also have diabetes or, you know, becomes a more complex patient.

**MR McNALLY:** Yes. I never cease to be surprised by what clients pull out when I think that it's going to be an easy case.

**PROF KING:** Yes, yes.

**MR McNALLY:** But, no, ACORN actually has something built in for that. So the effect sizes I was quoting before are severity-adjusted effect sizes.

**PROF KING:** Okay.

**MR McNALLY:** So you know, you take into account where the person is starting, so the smart thing to do is actually start with them when they're really in a crisis because their - you know, regression to the mean. They'll probably improve anyway.

**PROF KING:** That's right. True.

**MR McNALLY:** That's being really cynical about it.

**PROF KING:** Yes. 'I'll see you in four or five weeks when you're really - ' but it is a serious issue because - - -

**MR McNALLY:** Yes.

**PROF KING:** - - - when I said, 'You're talking to the converted,' the Productivity Commission previous recommended exactly the sort of reforms that you're talking about not just in mental health but more generally, so I'm really raising issues that were raised with us at that stage. Sorry, I am dominating the conversation.

**MS ABRAMSON:** I think bearing in mind the timeframe, Mr McNally, I might ask you to take the questions on notice if you intend to put a submission in perhaps to our inquiry. The first question really was about the cultural change that would be needed, so if psychologists aren't doing this type of assessment now, and I can understand why they mightn't be doing it, we would have to drive a very big cultural change program to get people to actually perform. It's not just psychologists, it's in the medical profession generally, so your thoughts on how that might be done would be very useful.

**MR McNALLY:** Okay. Yes, I see it as needing to be sort of like a multi-pronged attack. In other words, you know, even the training courses like the universities and schools of psychology and social work and, you know, nursing and whatever.

**MS ABRAMSON:** You might give some thought to that and the education that we have.

That would be terrific. The second question goes to how well those type of instruments would measure interactions with people of diverse cultures.

**MR McNALLY:** Yes.

**MS ABRAMSON:** So we're talking about a particular form of measurement which is associated probably with a western type of culture, so your thoughts on that. The other thing is also funding around a team-based approach in the private sector, so any ideas that you might have on how you do some of those things would be very useful. But happy to take those on notice.

**MR McNALLY:** Yes, okay.

**MS ABRAMSON:** And I've committed you to a submission, so if you're not in that position, just give us a call.

**PROF KING:** We strongly encourage you. We'd love a - - -

**MR McNALLY:** Consider it started.

**MS ABRAMSON:** Thank you so much. Thank you. Thanks, Steve.

**PROF KING:** Great, okay. Thank you very much. Then Prue Lynch. Thank you. Would you like this to be treated as a formal submission, by the way, or are you planning to read this out for transcript?

**MS LYNCH:** I'm reading this out.

**PROF KING:** No, that's good. In that case it will be on the transcript. That's fine, thank you.

**MS LYNCH:** Okay.

**PROF KING:** So if you can please just - your name, the role in which you're appearing and then any initial comments that you wish to make on transcript.

**MS LYNCH:** Good afternoon. I'm Prue Lynch, I'm a counsellor registered with the Australian Counselling Association, which I'll subsequently refer to as ACA.

Just a little background about myself: I have four years' study in psychology and a masters in counselling from Monash University and I'm a recipient of the Golden Key Award for Academic Excellence. I'm also trained in a multiple of therapies with proven results, and the Australian Counselling Association have told us stick to the draft, so excuse me as I go through and say on this page or that page or whatever.

So I refer to the draft volume 1 at the very start it says, 'One in five Australians experience mental health each year and the cost to the Australian economy is conservatively in the order of 43 to 51 billion per year.' It's my belief that counsellors registered with the ACA could

provide a great role in helping to provide cost-effective excellent professional and proven therapy to those experiencing mental ill health. But to do so, we need to be granted Medicare rebate provider numbers, and shamefully we are not. I think it's shameful.

Because most counselling agencies will only employ health providers - well, generally will only employ health providers with Medicare rebate numbers, counsellors are often locked out of providing help that is desperately needed.

Page 6 of the draft looks at key driving factors for poor outcomes in mental health. For example, under-investment in prevention and early intervention. Counsellors are outstanding at providing a psychoeducational therapy and wellness therapy for a vast range of issues which help problems from escalating in clients.

Many reforms need to be - and the draft then says, 'Many needs to be implemented in stages, and quickly.' It's my belief that at the very start ACA counsellors, especially with degrees, should be granted Medicare rebate provider numbers.

The draft also recommends early intervention including tackling early mental health and suicide rates. For example, when I was doing my masters, I had a year placement at a counselling agency which provides therapy for many clients with suicidal ideology and also the families who have loved ones which have committed suicide. Many ACA counsellors have also got experience in effectively counselling those clients with suicide ideology and their families.

Throughout my academic years, I have undertaken intensive study of stress, anxiety and depression, mindfulness and other associated studies in the identification of risk factors, and one of the draft - refers to the necessity for early identification of the risks to mental health of families and children.

It then goes on to look at suicide prevention and refers to a recent study which concluded that after care could reduce the prevalence of suicide attempts. I have been swift and active in educating clients about the systematic steps to take after a suicide attempt, or when they have experienced a suicide ideology. That might've been a bit dramatic, but I've been there, I've done that, and I've been effective, even though I don't have a Medicare rebate provider number.

Furthermore, I have been active and systematic in my communication with other care providers, to ensure excellent after care. And some of those other health providers, the psychologists, psychiatrists, basically by sharing what I found out with the clients, I'm able to help the psychiatrists tailor what medication will be presented.

The draft then also talks about access to psychological therapy at a level commensurate with the treatment levels. Throughout both volumes of the draft, the word "psychological issues" - and this implies a psychologist - it is vital that the draft reflects the critical role that ACA counsellors provide in mental wellbeing, and their potential if given a Medicare rebate provider number.

I feel like I've got a record playing, sorry. The draft also discusses person-centred care, which should be consistent. Research indicates that - quite a lot of research indicates - that approximately 32 to 33 per cent of successful therapeutic outcomes are due to the relationship that a client has with a therapy provider; this is regardless of the modality that they use. ACA counsellors are especially brilliant - if I may say so myself, but also from my experience - and develop empathetic, professional relationships with clients.

The draft then goes on to refer to the step model of care; in the step model of care, it fails to use the word "counselling," and again, I think dismissing any role of counselling or therapy, rather uses the word "psychological." I've certainly got the background in psychology, but I want to make sure that we're very aware of the opportunity that the ACA counsellors can present.

The draft then goes on about the strength of the Better Access Program is the ability to fund services at comparatively low cost. ACA counsellors would provide lower costs than psychologists. And it talks about the many interconnected determinants of mental health, which is found in the diagram on page 119. Again, counsellors are part of the determinants to reduce mental health in clients.

It also talks about the socioeconomic disadvantages, which has strong links to mental health and wellbeing. Many counselling agencies in Australia are financially struggling, and basically employ whoever has a Medicare rebate provider number, to provide their counselling, in order for them to survive. ACA counsellors are able to provide Medicare rebates to client; could help reduce the cost of hiring psychologists at an earlier level, and provide outstanding results.

And on page 47, the draft talks about "providing more bang for taxpayers' buck." I believe by providing ACA counsellors with Medicare rebate provider numbers, we can help to provide more bang for taxpayers' bucks.

**PROF KING:** Thank you. I'd like to follow up. We've heard from a number of different groups, including counsellors, other forms of therapists, and there seems to be a uniform call that, "Things would be better if only we could get Medicare provider numbers." And that obviously creates an issue from the government's perspective. We know about supply-driven demand in healthcare systems, so you can imagine that we'd be reluctant just to say, "Yes, open the floodgates to a whole range of different groups for Medicare provider numbers."

So my first question is, particularly given the previous presenter's comments, one way that we could judge who gets Medicare provider numbers is based actually on performance, on outcomes. So I was wondering, are you aware of any outcome-based evaluations of counsellors? Of particular interest would be outcome-based evaluations to compare the outcomes for counsellors versus the outcomes for other allied health professionals involved in providing face-to-face therapy. In a sense you've said, "Well, counsellors get outcomes." How do we know?

**MS LYNCH:** I don't know of any particular comparison. I do know that counsellors are - and this is not very professional - are a little bit - no, I'd better not use that word, there -

frustrated, because we can't get in there as much as we would like to, to be even able to provide probably, those figures, or a comparison.

I'll give you an example: I've been working at a Uniting Agency in Geelong. We used to be Wesley, and until we were taken over, even though I didn't have a Medicare rebate, I was given clients. I've been sitting through so many meetings in my staff, staff meetings, and my numbers have dwindled and dwindled and dwindled, of my clients, and I'm literally pulling my hair out because I'm not getting clients.

And the only thing that I can say, I know that two weeks ago, I did save somebody's life; I implemented so quickly - that's why I went like that - because damn it, I did that. I implemented a strategy to help make sure this person would survive. So I'm sorry, I can't provide those figures, because I just don't get the clients, and I don't think many of us who are outstanding are getting enough clients, because - - -

**PROF KING:** Yes, and it may be something that the ACA really needs to deal with at a larger system level.

**MS LYNCH:** They've - - -

**PROF KING:** Making sure they get that data.

**MS LYNCH:** Philip Armstrong, our president, has been knocking on government doors and health ministers for years and years and years. And I'm here; I want to kick your frigging door in. I know that sounds dreadful, but I think it's time to kick a door in to make sure that we're noticed, because we've been pussy-footing around and I don't think that where universities are churning out counsellors like anything, and counsellors of the calibre that I am, we are not - we've got our hands tied.

**PROF KING:** Behind your back, yes.

**MS ABRAMSON:** I suppose what Commissioner King was really getting at was more your industry peak association to provide, if they can, some data on effectiveness. So what Commissioner King was really talking about was if we have to allocate public funds - we've said this about a whole range of programs: we've asked for evaluations, like, how effective is it? Because that's part of the decision-making, so that's really what we were asking.

**PROF KING:** Yes.

**MS LYNCH:** Okay. Well, given that, I can't personally provide it.

**PROF KING:** No, no.

**MS ABRAMSON:** No, no.

**MS LYNCH:** But what I would like, if I could have some questions sent to me, to my email, I will make sure that the president gets back to you with those.

**PROF KING:** Okay.

**MS LYNCH:** So I think he will be much more effective in doing so than I would.

**PROF KING:** Okay, that would be fantastic. So we've got your email, so yes, Jane's nodding down the back. And again, this may be one that you want to pass on to the ACA: you mentioned that counsellors would not be as expensive as psychologists; any thought on what the MBS rebate would be for counsellors? So for registered psychologists I think it's around \$86.50 an hour. I'll look down at some people; yes, they're sort of saying that sounds about right. I think it's \$86.50 an hour for registered and about \$125 for a clinical, off the top of my head. So any thoughts on what the rebate would be for a counsellor?

**MS LYNCH:** Well, my thoughts are, if we did get a rebate, if we're fair dinkum about it, because we are not psychologists, I think we would need to be guided by the president, or by the ACA.

**PROF KING:** Okay, so - - -

**MS LYNCH:** And come up with a figure. But maybe - - -

**PROF KING:** That's another question that we can pass on. That's fine.

**MS ABRAMSON:** And because one of the things, Commissioner King, we will probably look at is where rebates are provided by private health insurers; that might be part of the mix, too.

**PROF KING:** Yes.

**MS LYNCH:** Well, basically, I don't know that that many people are at the ACA are actually getting a lot of clients coming in with the rebates.

**MS ABRAMSON:** No, I understand that. I understand that.

**MS LYNCH:** With private rebates, though. But maybe the rebates are so flimsy? For example, a Medibank Private might say, "Oh yes, you can get a rebate." But then you look into the actual policy you've got and you don't actually get it, or it's - - -

**MS ABRAMSON:** No, we understand there can be issues there.

**MS LYNCH:** Yes.

**MS ABRAMSON:** Thank you.

**PROF KING:** Any other questions, Julie?

**MS ABRAMSON:** No, thank you.

**PROF KING:** Okay, thank you very much.

**MS LYNCH:** Thank you very much.

**PROF KING:** So thank you all for attending today. I will now adjourn the hearings, to be reconvened - if any of you wish to join me - in Geraldton, tomorrow.

**MS ABRAMSON:** And can we also, on behalf of the Commissioners, thank the Commission staff?

**PROF KING:** And thank the Commission staff.

**MS ABRAMSON:** For their huge amount of work that they've put into the hearings.

**PROF KING:** But they're all going to be with me in Geraldton tomorrow.

**MS ABRAMSON:** They're not looking too enthusiastic about the big night flight to Perth, Commissioner King.

**PROF KING:** Right, thank you very much.

**MS ABRAMSON:** Thank you, thank you very much.

**MATTER ADJOURNED UNTIL  
WEDNESDAY 20 NOVEMBER 2019**