



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

PUBLIC HEARING INTO MENTAL HEALTH

PROF STEPHEN KING, COMMISSIONER
PROF HARVEY WHITEFORD, ASSOCIATED COMMISSIONER

TRANSCRIPT OF PROCEEDINGS

QUALITY HOTEL REGENT ROCKHAMPTON 192 BOLSOVER STREET
ROCKHAMPTON

ON MONDAY 2 DECEMBER 2019

INDEX

	<u>Page</u>
QUEENSLAND ALLIANCE FOR MENTAL HEALTH CRAIG STANLEY-JONES	3-11
JOHN PINK	11-17
HEADSPACE DEAN HYLAND	17-27
RISE ABOVE ACES GROUP BRONWYN REES	27-37
ANGLICARE CENTRAL QUEENSLAND JENNY SMITH	37-48
EATING DISORDERS QUEENSLAND BELINDA CHELIUS	48-57, 61-63
TRIPLE P INTERNATIONAL CAROL MARKIE-DADDS	57-60, 63-66
ROBERT WELLMAN	67-74
ANONYMOUS	74-83

PROF KING: Good morning all, and welcome to the public hearings following the release of our draft report for Productivity Commission's Inquiry into Improving Mental Health in Australia. My name is Stephen King and I am a Commissioner in this Inquiry, and beside me is my fellow Commissioner, Harvey Whiteford.

Before we begin today's proceedings, I would like to acknowledge the Darumbal people who are the traditional custodians of the land on which we are meeting today, and pay my respects to their Elders past, present, and emerging. I extend this respect to all Aboriginal and Torres Strait Islander Peoples in attendance today.

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

Submissions and comments to the Inquiry will close on 23 January. Participants and those who have registered their interest in the Inquiry will automatically be advised of the final report's release by government, which may be up to 25 parliamentary sitting days after completion. We will conduct all hearings in a reasonably informal manner, but I would like to remind participants that there are clear structures in our legislation for how these hearings are legally backed.

A full transcript is being taken. For this reason, comments from the floor cannot be taken. The transcript today will be made available to participants and will be available from the Commission's website following the hearings. Submission are also available on the website. Participants are not required to take an oath, but should be truthful in their remarks. Participants are welcome to comment on issues raised in other submissions.

I also ask participants to ensure their remarks are not defamatory of other parties. You are all free to enter and exit the room as you want, and if anyone needs a quiet space, please feel free to exit the hearing and use the space by the coffee and tea area. If at any time you feel distressed, please approach one of our staff, who will assist you.

In the unlikely event of an emergency requiring evacuation of this building, the exits are located down the hall in which we came in, to the left and right, and upon the evacuation tone, please leave the building and assemble in the carpark, which is out to the side to the left of this room, if you are facing me, unless an alternative assembly location is notified by the fire wardens.

Our first participant today are going to be representatives from Queensland Alliance and Mental Health, and we will now ring them in. Hello Craig, Stephen King here. I'm here with Harvey Whiteford, and we've just started our hearings. You're okay to have a bit of a discussion at the moment?

MR STANLEY-JONES: Yes. Yes, that would be good. I was expecting you at ten past 9, but (indistinct).

PROF KING: No, no, we're just a little bit early. Very efficient.

MR STANLEY-JONES: No worries.

PROF KING: That's what happens when you're dealing with the Productivity Commission.

MR STANLEY-JONES: Great, thank you.

PROF KING: So formally, Craig, could I ask you to state your name, any body that you're - organisation that you're representing, and if you've got any opening comments that you'd like to make.

MR STANLEY-JONES: All right. My name's Craig Stanley-Jones and I'm a board member on the Queensland Alliance for Mental Health. In terms of opening comments, I appreciate the opportunity to present a point of view of Queensland Alliance and broadly of members here today.

PROF KING: Thank you. Can I run through a few issues? So, your initial submission focused, I think, really on four areas. So I'd like to run through those, and have you had a chance to have a bit of a look through our draft report and the recommendations there?

MR STANLEY-JONES: Yes.

PROF KING: Yes.

MR STANLEY-JONES: Yes, I have, and just wanted to provide some feedback (indistinct).

PROF KING: Yes, okay. So let's try and - happy to have your feedback as we're going through. So your initial submission, first focus was on rural, regional, and remote issues. Any comments that you want to make sort of following up now on our draft report, particularly on where we've dealt with rural issues.

MR STANLEY-JONES: Look, only in relation to - yes, to the need of people in rural and remote communities. I mean, there's probably no further comment in relation to what we've already submitted there in relation to rural and remote communities. I mean, needless to say that, you know, the NDIS more broadly is not - is not addressing the needs of people in rural and remote communities, and I know there's moves underway to address that. Yes, there seems to be a marked failure there in terms of the work being done in that space. But I think that's already been noted at different times there.

PROF KING: Okay. What then about the workforce issues? So we've got a couple of workforce issues that we discuss in the draft report. But any thoughts on particularly the workforce issues for the community mental health sector? Your thoughts first, and then let's have a bit of a discussion about that, if there's any issues you want to raise.

MR STANLEY-JONES: Yes. Look, from our point of view, in the community mental

health sector, there seems to be a lack of acknowledgment of the community mental health sector in the report, and the workforce and its capability. Yes, the workforce does have an ability to provide primary and (indistinct) care, its ability to provide low intensity services, a Stepped Care Model.

Yes, the community managed mental health sector does respond to acute and sub-acute in the form of community special services, and there's a lot of integrated areas, integrated - currently integrated work with clinical specialists, mental health sector and (indistinct) local health and hospital districts throughout the country. Our view is that there's insufficient - it's insufficient in addressing the breadth of the community sector that (indistinct) mental health sector is (indistinct) care or intervention, social inclusion, and emotional and social wellbeing.

But largely, the community mental health sector is invisible in the report, and in our view, if you continue to maintain the medical and health care model - just to give you a bit of an analysis (indistinct) the funding for the sector has dropped off since the (indistinct) mentors and Partners in Recovery program which rolled into the National Disability Insurance Scheme, and, you know, in many respects, the work of the community managed mental health sector unfortunately is lost because it's not clearly defined. It's not clearly identified in the Australian Health Institute - Australian Institute of Health and Welfare reporting.

It's not clear in the Australian Institute of Health and Welfare (indistinct) where the community mental health sector fits. It sort of fits in emergency and ambulatory care, but it's sort of lost, and the capacity to identify the work of that sector is lost. As a consequence of that, and as a consequence of a large portion of funding growing in the National Disability Insurance Scheme, and you've probably heard these numbers before, but there's roundabout 690,000 people across the country who require psychosocial support, and we understand that there's about 54,000 people who will be able to access the NDIS (indistinct).

PROF KING: Yes, yes. Okay. So let me follow up on a couple of things there. So you mentioned things like Partners in Recovery, and we talked about, particularly for people with more complex mental health issues, we've got recommendations relating to navigation, service navigation, care planning, and so on. And one person actually said to me in a hearing, it sort of seems like you've reinvented Partners in Recovery, and the answer was sort, well, yes.

So your thoughts, if you've got some, on that - those recommendations, around care navigation, and also - I'll then come back to a bit on workforce, and then pass over to Harvey, if he's got any questions on this issue. But just firstly, on that care navigation. Do you think we've got that right? That we've gone far enough, or what would you like there?

MR STANLEY-JONES: Look, in terms of feedback from stakeholders, I think that's along the right track. Certainly, Partners in Recovery, from feedback from consumers, carers, and the sector was very positive about the work that happened in the Partners in Recovery space. In essence, it did engage people who ordinarily wouldn't be engaged in the mental health system. So in many respects, it was achieving what it set out to do, particularly for people with severe mental health issues. So people who may be homeless, or at risk of homelessness in particular.

So that sort of navigation that's referred to, I think is along the right track. I guess it was, to me, a little bit unclear about, you know, what the depth and breadth of that service coordination could be. I mean, if it was along similar lines of Partners in Recovery, I think, you know, that would (indistinct) in a much better place to continue to be able to navigate the system.

I think, just along those lines, and a number of you are unsure or - both yourself, Stephen and Harvey, are you familiar with that report in 2015, the Australian government response, it should be (indistinct) driving communities. A review of mental health programs and services. That was distributed by the Department of Health in 2015. Are you familiar with that?

PROF KING: Yes.

PROF WHITEFORD: Yes, we are.

MR STANLEY-JONES: Yes. I mean, that particular document, again, you know, it (indistinct) with, you know, the attempts to - or the support for people, you know, in an integrated system of support through something like Partners in Recovery, and certainly that's - that document, you know, is a helpful guide into - into the impact that - the positive impact that the community managed mental health sector could make. And I think, you know, as far as Partners in Recovery is concerned, and the way the Productivity report has addressed it, I think from our members' point of view is certainly consistent with the positive impact that Partners in Recovery had.

PROF KING: Okay. I was just about to ask exactly the same question, so do you want to do that?

PROF WHITEFORD: So Craig, it's Harvey Whiteford. Thanks for that. We say a lot in the report about psychosocial support, but we have heard from a couple of different people at the public hearings that the NGO, or the non-government community mental health sector's been not well presented in the report. And there seems to be a disconnect between what we've said about the importance of psychosocial support and the essential role that plays, compared to the sector and the people who are delivering that, and some of that appears to be about the - what's happened with the NDIS coming in.

But can you say a bit more about the sector and how it's not appropriately presented in the report, and who the workforce is that makes up the bulk of the service provision in the sector.

MR STANLEY-JONES: Sure. So, as we understand, I have some figures here. In 2017, there were around about 30,000 people working in the community managed mental health sector space. So to define that, that's - that is people who work for NGOs, so not-for-profit, working usually in the non-clinical psychosocial support space. And since 2017, you know, the impact of the NDIS, you know, has had a considerable impact on the workforce as a consequence of that.

And also too in the way in which the work of that workforce, or the outcomes, or the support

for people with mental health issues is identified in that workforce. This is a real issue for being able to measure the strength of the workforce. Largely the workforce is, when it comes to reporting at the moment, is mixed in a range of different streams within the Australian Institute of Health and Welfare reporting.

So at the moment, it's mixing sub-acute reporting. It's also mixing non-ambulatory reporting, and when there's a description of a community managed mental health sector in these reports, sometimes that's referring to government run services that are providing in the community. So it's a (indistinct) to articulate the work of the community managed mental health sector and the not-for-profit work. It's hard to identify currently, as a consequence largely of the funding rolling into the NDIS.

Because there was a view in 2017 that it did need to be recorded or reported anymore. So the impact that the sector has had, you know, up to that point, it was being recorded, although since then, it's not, and during that time it hasn't been clear. I guess what I did - what it did say, that the rate of mental health presentations had - indeed, the Productivity report did say (indistinct) over the past 15 years, and look, we would argue that that's on the back of the community managed or community-based support, and the impact, you know, that that sector had hasn't been - and the workforce hasn't been well supported over that period of time.

PROF WHITEFORD: So Craig, can I clarify something there? We've been told that the minimum data - the NGO minimum data set which was developed by AIHW and then sort of parked, two jurisdictions have collected that data, one of them being Queensland, the other being WA, I understand. Is what you are saying, that that's no longer recorded since 2017? Or is it still recorded, but not compiled and sent off anywhere?

MR STANLEY-JONES: Well, I think there are two issues. That if it is recorded, it's not recorded for the use of the Australian Institute of Health and Welfare, and then secondly, as has been explained from a variety of stakeholders and peak bodies is that if there is any recording of it going on via Queensland Health, for example, or various health departments, or state departments, it's lost because it's fragmented into a range of different service types that don't adequately describe the sector. Don't clearly describe the sector.

So in essence, for example, it's recorded in Queensland Health data and non-hospital data, non-ambulatory data, rather than the (indistinct) data in of itself.

PROF WHITEFORD: Can you pull it out of the Queensland Health data set, do you think?

MR STANLEY-JONES: Well, if you take it - it would take some significant analysis from the department and/or the sector to assist in that process.

PROF WHITEFORD: Yes.

MR STANLEY-JONES: I don't think it is. I don't think - it's not clear. It's not clear to many people.

PROF WHITEFORD: Okay. So I'm not asking you whether you would do it. I just want to know whether it's doable. But it seems a shame that the data is collected, but it's not -

maybe, as you're saying, it's not collected as comprehensively as it should be, but it's not being used.

Can I just ask another question on that then? From your experience and just what you know about the sector, what sort of workers make up the bulk of the workforce in this sector and the second part of that question is have you got any comment to make about Aboriginal mental health workers or cultural capability in that sector?

MR STANLEY-JONES: Yes, sure. So look, the bulk of the sector is made up of people who have, you know, a range of human services, tertiary education in their (indistinct). So the people with social work, psychology, occupational therapy and in some cases nursing backgrounds.

But generally, they're social work, psychology OT's. And then there's obviously, in some - more recently, I think, in terms of - in terms of the workforce, you know, (indistinct) because at the moment the core funding for the sector comes through the NDIS and it's just not possible to employ people for that period and capability in the psychosocial sector, the non-clinical sector as it once was.

So there is a - I think the bleeding of people with - that (indistinct), that background, that capability, largely going - going into Government, for example. There are a small number of psychiatrists and GP's who have come into the sector, a very small number and they're connected through the not-for-profit sector through specialists, step up, step down programs, through Headspace, for example, but really that - you know, negligible in the scheme of things.

And you know, in many instances, if that was a larger - larger church affiliated church-based organisation, they're much larger NGOs to continue to prop up, if you like, the NDIS sector. Or the NDIS supports.

In many respects, and you've probably heard many of these instances, but there are, you know, very successful mental health NGO's, national mental health NGO's that have invested millions of dollars per year and if it goes flat, of course, before the (indistinct) recently, I'm also employed by an organisation that had 3000 staff across mental health affiliations that they'd already (indistinct) that we have just (indistinct) also the drug (indistinct) disability space as well.

It's just we're not able to provide the service and (indistinct) at an organisation (indistinct) they'd have to say (indistinct) a small number of (indistinct) each year and - and we could no longer (indistinct) that, so - but (indistinct) workforce (indistinct) suspect that it's - it's very difficult to say the least in the current environment where NDIS is largely focussed.

PROF KING: So can I - can I follow up a little bit on that before we move to the Indigenous workforce in particular, but for that general workforce, we made obviously the recommendation about contract lengths being extended for the - for the community supports which is hopefully to partly address some issues of workforce job stability as well as contract stability.

But what are the specific recommendations would you want us to make to the Government in May about the community based community mental health workforce? What recommendation is there that you think would help move the sector forward?

MR STANLEY-JONES: Well, in terms of the workforce and the workforce being connected to, yes, people – people with a psychiatric disability, people with – for their specific mental health issues. I mean, there – and people with moderate – moderate to severe mental health issues, who will miss out on the NDIS. So (indistinct) to address those needs. We would recommend – the sector would recommend that funding for people who are ineligible or unable to access the NDIS, we would recommend funding that supports people with moderate to severe mental health issues, and to take pressure off the hospital system. The hospital system in each state, the ED department in each state.

And there needs to be support there for the workforce of people in their not-for-profit sector. I mean, the not-for-profit sector does provide services – does provide services more cheaply or more effectively than the government paid services. Now, in order to prove that, we did the data through that.

But there hasn't yet been a range of reports dating back – dating back to the early 2000s when it came to the Queensland-made report that was commissioned by (indistinct) and they've got their Queensland (indistinct) research around how the support program and the impact of supporting people in the community and in their own homes, whether it was spending, you know, up to a year in and out of ED departments and you know, (indistinct) residential (indistinct).

PROF KING: Sorry, Craig, have you got reference for – to Tom Mien's work on that that you can point us to? Or we could contact Tom directly, I suppose.

MR STANLEY-JONES: Yes, I'd have to contact Tom directly. I know the report – the report was that there was - you were the (indistinct) support program (indistinct) and Tom did a 10 year study over – over the course of the mid-nineties to the early-noughties. And I think he released his final report actually in in 2010, but I – yes, Tom would be the best to answer that.

PROF WHITEFORD: Okay. We'll follow up with Tom.

PROF KING: Can I also just – I just want to make sure that I'm hearing you. So one of the things we heard in Broken Hill in particular was they said, 'Well, your money and more resources going into one thing. Fill the resource gaps that have been left by the NDIS. But the view also in Broken Hill was that once you get outside the capital city, so that the workforce isn't there. So just putting in money by itself is not enough.

And so I was wondering if you had any thoughts on that? I mean what do we need to recommend to the Government, not just in terms of we'll pop the money out there, what do we need in terms of a workforce strategy so that, you know, Rockhampton, Bundaberg, right up the coast, right through, you know, go out west in Queensland, so that, you know, so that the workforce is there, because you can pump dollars in, but if there's no one to deliver the services, you're not going to get anything.

MR STANLEY-JONES: Yeah, yeah, I mean that's a – a significant challenge as you rightly identify. I think in terms of pumping money to the regional and remote areas, certainly if there's – if there's appropriate services, so I'm thinking of a place like Rockhampton, for example, where I know that the State Government has recently invested in step up step down facilities and built facilities to assist these transitioning people (indistinct) mental illness, out of hospital and into the community. I mean, that's one end of the spectrum.

You know in terms of the (indistinct) and in terms of the – people with moderate to severe mental health issues. I think – I think, (indistinct) like that does encourage, you know, people with tertiary qualifications to you know, moving to reasonably remote areas. I mean, it's part of a wider vision. There's no point challenging that we have answers to (indistinct).

But in the sense of the cost of living, obviously, the cost of living in reasonably remote areas, I mean, that will always be an attractive feature and I know that, you know, Queensland Health and various State Departments throughout the country, you know, who tend to employ people locally, also attempt to employ people from overseas, while being a local capability, is there, so it's open ended.

Enacting a whole range of possible responses in terms of addressing perhaps the lack of inappropriate workforce capability in rural and remote areas, certainly, in terms of like, coming back to your question: are there (indistinct) relation to social and emotional wellbeing in the Aboriginal and Torres Strait Islander workforce.

Again, from a service point of view, (indistinct) I don't suspect that they'd all say from the perspective of the Queensland (indistinct) of mental health, yeah, we were work closely with a range of Aboriginal controlled services and will be, as a (indistinct) service, for example, we work in partnership across a range of programs, Government (indistinct) services are.

It is also a challenge for the not-for-profit Aboriginal and Torres Strait Islander social management and (indistinct) services to (indistinct) when there's competition here from Government sector and Government sector generally pays better. So just recently, we employed two Aboriginal and Torres Strait Islander staff at - just from a personal point of view, for the organisation I work with. We work in a homeless space, we employed these two Aboriginal and Torres Strait Islander staff in May and by August they were offered you know, positions that they couldn't knock back and took up those positions in the Government, you know, for better pay that you know with 15 to \$20,000 greater.

So it is a challenge for the not-for-profit-sector to maintain good – yeah, what we've worked – catering for staff in the Aboriginal and Torres Strait Islanders. But it is a – is expected as quite robust, certainly from a Queensland perspective. And no – yes, from our perspective, there are organisations that we work very closely with – yes, the likes of – in Queensland, in Brisbane, the (indistinct) place, Institute of – IUIH. Institute of Urban Indigenous Health.

And there's enough of a range of other organisation that we also work with here in Brisbane, and to pass the (indistinct) as well. Was your specific question in relation to social,

emotional, workforce and Aboriginal and Torres Strait Island workforce as really about how that workforce is maintained?

PROF WHITEFORD: Yes, no, I think what you've explained there is supports what we've heard in other places and obviously to – it's a challenge in the area.

MR STANLEY-JONES: Yes.

PROF WHITEFORD:

I think that's all I had, Craig, so thanks very much. That was very useful so I appreciate you taking the time to be on the call with us.

MR STANLEY-JONES: Pleasure. Thank you, thanks for having me.

PROF KING: Thanks, Craig. Thank you, we'll log off.

MR STANLEY-JONES: Thanks, Stephen. Bye-bye now.

PROF KING: Bye. Bye. John, would you like to be on next?

MR PINK: Yes. Over here?

PROF KING: Yes, if you could just sit there and - - -

PROF WHITEFORD: John, this is (indistinct words).

PROF KING: Yes, but the air-conditioning's going to blow us away before morning tea, otherwise, so. Morning John. If you'd be able to state your name if you are representing an organisation, what organisation you're representing. And if not, that's fine. And then any open comments that you'd like to make.

MR PINK: Okay. My name is John Pink and I just want to - - -

PROF KING: Now, I think you're about to show a diagram.

MR PINK: Yes.

PROF KING: The only thing is, if you can explain in words anything you want to show, because obviously the transcript can't see the diagram.

MR PINK: All right. Yes. Okay. Name's John Pink. I'm completely out of line, no organisations except the one that kicked me out. So you won't have to worry about me expressing someone else's view. Now, what was the third thing?

PROF KING: Then just any opening comments you'd like to make.

MR PINK: Yeah. The main thing is to the productivity commission, I put in a very simple, I guess you'd call it, chart, right? It's a table and I'll read the opening sentence on the table:

Mainstream Psychiatry is Exposed as Being Unscientific as it has No Answers to Very Basic Questions.

These questions and the questions are up there, there's one column on the left-hand side of the sheet, concern quite well known phenomena associated with mental ill – well, you call it mental illnesses. I don't. I call it mental development.

PROF KING: M'hmm.

MR PINK: I got my book open and one thing I noted down is no one has ever dealt with this and I think you should consider these people who have mental illnesses as a resource, rather than a consumer of money and therapist time and all that sort of thing. I think you should consider them as a resource.

Now, you shouldn't consider me as a resource. You've already lost – I'm already gone. I'm – I'm off, right? But these other people who are suffering mental illness are actually lower down and they've yet to do – to advance onto what I'm doing, right? And I consider these people who have mental illness too advanced to do this test. It's a test and when you're through the test your mind is more powerful. You can do more, cope with more, and you've got to be more careful of how you use it.

And it's such a – although it's a difficult experience, I have a lot of compassion for people who are going through it, and the people that care for them, they're also very special and they should note down everything that happens in a journal and one thing I regret not doing is journaling, right, everything that happened because it's possible later on they'll want to track exactly what they did.

I certainly want to track it, right. And one particular thing I – which I can't get, right, is from a university. And the university was Macquarie University - see there are some people that agree with me - or I think no, right, these people are actually gifted already. You've got to be gifted to have a mental illness, right.

And this one was Professor of Psychology at Macquarie University on Northside of the Harbour. Don't worry I'll stick it in an email, right? Now, I can't remember her name, but she was quite young to be a Professor. But she did one thing which - on the second week – and I remember it's the second week because there was a drawn Grand Final at the Sydney Cricket Ground.

PROF KING: Okay.

MR PINK: And I would have been late for this session, right - there were three sessions over three separate weeks on the Saturday, starting at 4. I would have been late because that's when the Grand Final finishes at 3.20 or something like that. And the only reason I wasn't late was I was drawn.

And it was Paramatta and St George, I believe, right? The year was 1977 and they were drawn at full-time, they played 10 minutes extra time and they were still drawn so it had to play the following week and the second – this was the second week of the course, right?

Three consecutive weeks, it was run over. And she put these probes on her head which measured brainwave activity, so she said, I don't know if they did, right, but so she said.

She put them on, I think, with petroleum gel, we didn't have the water-based gels then, and she used surgical tape - and you just rip it off and stick it on - and she told us the readings to expect and my reading was double the reading that - that she told to expect.

PROF KING: Yes.

MR PINK: I remember sitting there at the time and thinking, 'But I'm not relaxed.' I'm a pretty nervy sort of guy. Even after I've recovered, I'm still nervy. Yeah. That's not changed. I'm not as bad as I used to be, but I'm - anyway, I claim she knew that people's minds are more powerful and the evidence for it is that they've had a mental - they're having a mental illness. They're struggling through. Now, I - I see it as an empowerment process.

That's probably the most important thing I've got to say. There's another one, if you want to check on resources, there's one guy I'll refer you to, that's Robert Whitgar and he's written a -
- -

PROF KING: Sorry, Robert?

MR PINK: Whitaker.

PROF KING: Oh, okay.

MR PINK: I'll stick it in the email, right?

PROF KING: Yes.

MR PINK: He's the founder of Mad In America. For eight years, we've campaigned to have something done at - again, I think it's - I'd say now biological psychiatry where they give them pills to cure them. Right? And he's saying that you give them the pills and it makes it worse. But I still dig up new stuff out of his stuff and I don't think he sees the value of it, right? This last report I've got he's saying after three years these people that are only given the pills improve dramatically. Now there's one psychiatrist, he was called the lead or - and is called the lead, and in another obituary in the newspaper he was called the leader psychiatrist for the twentieth century. He was Dr Karl Menninger, M-e-n-n-i-n-g-e-r, and he run a more easy going institution called the Menninger Foundation. He noticed in these people - and it was - I think it was over 35 years ago he put it in his newsletter, he actually produced a newsletter for the mental health patients to read and that, you know.

He had in there - in the newspaper, he noticed that some - and on the successfultschizophrenia.org website, right, and it's a west coast of America based group, won't talk to me which is typical for - I'm a total loner, I've no allegiance to anyone, no one accepts me. He said he noticed somebody's long term place if recovered - and he said not just recovered but after they'd recovered they went on to do some really outgoing things like establishing businesses and all these sort of thing, right?

PROF KING: Yes.

MR PINK: He termed it weller than well. I wouldn't term it weller than well. I would term it they were initiated, and it's a word I - when I first encountered it I'm reading this word and this is a strange word and I finally got to understand what the word means, and I've produced a diagram but you didn't get the - I've sent it to Bill, right?

PROF KING: Yes.

MR PINK: But it didn't go in (indistinct). I only put this one in. This one has very - - -

PROF KING: Sorry, just again for the transcript. Now you're back to the first diagram.

MR PINK: First diagram under lack of understanding.

PROF KING: Yes.

MR PINK: My claim is the lack of understanding and what's fundamentally going on when the person is going through what you call mental illness. I call it mental development, and I'll go through some of the questions. Why is it common for people suffering from a mental illness to hear voices? It's the first question they ask you when you go to the hospital, 'You're hearing voices?' The second one - and this is - actually there's two, one's a guy who's a psychiatrist in England. Right? (Indistinct) if it's the UK. Dr David Kelly is his name. He runs the livingwithschizophreniauk.org website and on one of the webpages he's got - I think the figure is - he notices people with mental illness have this religious delusions and I think he may say the figure's actually 50 per cent.

Now, it's also in ResearchGate, right, and I'll give you think link to that. There's a psychologist, he was a lecturer in psychology at the University of Arizona, and I forget his - I think I forget his name, but I can get it.

PROF KING: John, so I take your perspective and I want to - and I can see it's a perspective - I can imagine many people would sort of not have the same perspective, but I want to see the importance of the perspective for outcomes. So let's put the pills, the pharmacological treatment, to one side for the moment.

MR PINK: Yes.

PROF KING: So, as you said, you do it as a test, and they may be struggling during the test. With your perspective, would you say, well, they should be helped in that test, so there should be the community-based services to help them whilst they're going through that test? I mean, so would your submission to us be, well actually, we need the support for those community services, whether it's employment services or services in school, or services in housing.

From your perspective, they're going through a test, but it makes it easier for them to go through the test. Would you see that as a legitimate role for government, to fund those sort of community services for the people going through, as you said, the test?

MR PINK: Yes.

PROF KING: Okay.

MR PINK: Look, I went best away from my therapist, really, and the good thing, when I say I had a therapist, I had Jungian analyst, and I even moved away from him, simply because I had so much trouble with the psychologist. I've found these mental health experts, or the mental health professionals, to be that control-freaky, I couldn't stand it. You know, and I think I'm fairly tolerant. Now I've got nothing but praise for them at the start of my treatment. In fact, my recovery may not have happened, or certainly wouldn't have been as powerful, without their involvement, and I still wonder to this day why they behaved like they did.

In other words, their behaviour was that poor at the end, from this excellent, nothing but excellent treatment at the start. It was phenomenally good. It was brilliant, yes. But I noticed, as I started getting better, I started having more and more problems with these people, you know. And look, there's a guy I'll refer you to, is Lanny Beck. What happened was, Pierre Trudeau, they deinstitutionalised in Canada and in the UK, right.

PROF KING: Yes.

MR PINK: And in Canada, you're allowed to apply for money to establish things. Well, they were given money and they purchased a house, right. And they also collected from the people they were getting their dole benefits, or whatever the equivalent is over there. In the end, they were called the Mental Patients Association. They owned half a dozen houses. They actually did a film on it.

PROF KING: Yes.

MR PINK: And I'll send the link to the film. They won't talk to me, but I'm pretty sure they'll talk to you. They actually made a film with these people. I told you before, they were very gifted. Give them the money; this guy Beck organised them and they owned half a dozen houses when they shut down.

PROF KING: Okay.

MR PINK: I mean, you know, that's not silly. That's very controlled. Clever.

PROF WHITEFORD: So John, thanks for what you've discussed with us. I think it's important. What I heard that you said, which I think is important, is that we have to think of people who have been through those experiences as a resource as people who can provide information that we don't otherwise have.

MR PINK: Yes.

PROF WHITEFORD: From a perspective that people who haven't been through that experience don't have, and listen to them more about how we can make the services better.

So, from that point of view, I think what you said does resonate, and thank you for taking the time to come all the way that I understand you have come to be able to be here and present.

MR PINK: Glad to come here. Look, I'd even say more than you, I'm seeing - these people will produce dollars for the country, right, because they are that clever. They're the top of their line. They're the top. You know, not just they've got a lot to say about the treatment, right. I don't think these people say much about - they'll just get on with it and produce money for the country.

PROF WHITEFORD: Great.

MR PINK: I mean it. I think these people are clever. They were clever before they had the mental illness, and the mental illness (indistinct) they were clever.

PROF KING: One last question from me, and it's on the medicine side. So we've heard from different people their experience with the medicines, and some have said, yes, but they don't think the medicines work for them, and so on, which you - would agree with your position. We had other people who said, gee, if - well, one example we had, someone said, look, if it wasn't for the medicine, I'd be dead now. That they were suicidal and the medicine stabilised them. I mean, is it always the case that the pills can't help, or is it just a matter of sometimes they help, sometimes they don't.

MR PINK: I'll refer you to Yale University. They actually had a placebo department, and what they did was they measured - I think it was a double-blind test, right. They found there was a two per cent difference - two per cent improvement in mental condition, right. Only two per cent, right, from taking the pills, the ridgy-didge pills, or purported to be ridgy-didge pills, right. The clinician, they also said, has got see a seven per cent improvement before they notice it, before they pick it up.

PROF KING: Okay.

MR PINK: They actually have got a video where they - where they're marketing this - these placebo pills because they consider that as long as they don't claim they're a legitimate antipsychotic drug, right, they can market them. But they found, even when then tell people it's a placebo, there was improvement. Yale University's the one to talk - don't talk to me. You know, I don't know much about the pill.

PROF KING: All right. Well, thank you, John.

PROF WHITEFORD: Thank you, John.

PROF KING: Thank you very much. Thank you for coming so far to talk to us.

PROF WHITEFORD: So can we get a copy of the - the one you didn't give to Bill, if we could get a copy of that for the - - -

PROF KING: Yes, if you can get a copy of that to Bill, that would be fantastic.

MR PINK: Yes, I'll just email it to Bill.

PROF WHITEFORD: Yes, thank you very much.

MR PINK: (Indistinct). You're obviously going to have no one turn up this afternoon. I'm only staying to talk to people, right. I may as well clear out now.

PROF WHITEFORD: That's fine by us.

MR PINK: Otherwise - - -

PROF KING: Up to you.

PROF WHITEFORD: Whatever's easiest.

MR PINK: I don't think anyone's going to turn up, so why put your people under stress.

PROF KING: All right. Thanks, John.

PROF WHITEFORD: Good on you, John. Thanks for coming.

MR PINK: No, thanks for accepting me.

PROF KING: No, thank you.

MR PINK: Thank you.

PROF KING: Next, we've got Dean, I think.

PROF KING: Dean, if you don't mind introducing yourself for the transcript, stating your organisation and any opening comments that you'd like to make.

MR HYLAND: Thanks, Stephen. Good morning to you all. My name's Dean Hyland. I'm a registered nurse and a credentialled mental health nurse. I'm currently the centre manager at headspace in Bundaberg, and have been in that position for the past eight months. I'm attending this morning as an affiliate of both headspace and also the lead agency for whom I work, and that's United Synergies.

I would like to start by acknowledging and paying my respect to the Darumbal people, the traditional owners of the land on which we meet. I would like to pay my deepest respects to the Elders past, present, and emerging, and acknowledge all the Aboriginal and Torres Strait Islanders here today, also paying my respects to the Elders past, present, and emerging.

I'd like to thank the Productivity Commission for the opportunity to speak today, and applaud the Federal government for undertaking such a significant and important review. I'd like to highlight to the Commission, and assist it to understand, that often the mental health of young people, or young Australians, is the key to the nation's productivity and economic success.

Whilst I'm in no regard an expert, I've been indeed fortunate to have worked in rural and regional Victoria, rural and regional NSW, Darwin, east Arnhem Land, Cape York, and now in Bundaberg, in the Wide Bay area. I've mostly worked in the area of community-based mental health, and mental health and drug and alcohol treatment services, both government and non-government agencies. Prior to relocating to Bundaberg, I was a clinical manager for the first service, or health service in Australia that incorporated two states; both Victoria and NSW, and that's in Albury-Wodonga.

Headspace, formally the National Youth Mental Health Foundation, is an Australian not-for-profit organisation for youth mental health, established by the Australian government in 2006. Headspace is funded by the Department of Health and Ageing under the Youth Mental Health Initiative program. In speaking this morning, I'm hoping to assist the Commission to understand that optimum mental health of young people, or young Australians, is the key to the nation's productivity and economic growth.

The general public understand headspace primarily offers mental health service to the 12 to 25-year-olds with low to moderate mental health issues. Headspace actually delivers a whole lot more than that. Headspace provides support to young people aged 12 to 25 to reduce the impact of depression, anxiety, stress, alcohol and drug use, and to improve relationship issues associated with sexuality, sexual health, families, and bullying. Young people and their families can also receive support at headspace centres, as well as online and telephone supports such as eheadspace.

At a localised level, headspace is involved in community engagement opportunities through a multidisciplinary approach and supported and guided by a consortium of local, non-government and government agencies. The importance of early intervention and detection needs to be a priority area for the positive impacts upon the mental health of young Australians. A brief background you're probably all aware of. Headspace, and the positive it's had on young people, is the following.

So since the inception in 2006, headspace has supported over 250,000 young people over 300 million - sorry, three million services. In the past year alone, 99,892 young people received support via headspace, including out of those over 9,000 Aboriginal and Torres Strait Islander young people, almost 11,000 culturally and linguistically diverse young people, and almost 26,000 young people who identify as LGBTIQA plus.

More than 62 per cent of young people get better with headspace, and this increases to 68 per cent if they attend five or six more sessions. Young people report higher levels of satisfaction with services, such as headspace 85 per cent, headspace centres 87 per cent, and headspace early psychosis 94 per cent. 77 per cent of young Australians recognise headspace and they know that that's the place for them to go.

A recent follow up study of more than 1,900 young people found that young people's distress levels and functional recovery improved using headspace, and continued to improve for more than a year after that. The majority of participants reported high or very high levels of psychological distress upon entering headspace. All age groups reported a decrease in psychological distress using the Kessler 10 whilst at headspace, and most age groups reported

further improvement after leaving.

Most participants, total 84 per cent, reported that headspace positively impacted their mental health, literacy, and helped them better understand their mental health problems. Participants also reported developing skills to deal with mental health issues, highlighting the important role that headspace plays in equipping young people with the tools and the resources to better manage their day-to-day mental health. And importantly, 78 per cent of participants reported that headspace has positively impacted on their work and study situation.

Headspace in Bundaberg is a partnership of local health and government service organisations provided under the auspice of United Synergies. They are my lead agency and their head office is in Tewantin. Our aim is to provide full integrated, free, primary health care services for young people in one youth friendly environment. Each centre is slightly different in its approach to service delivery, because the centre is guided by local community needs. Each centre has a youth committee that provides a youth specific lens and is directly involved in the running of the centre. Each community has differing needs, and therefore requires custom made interventions and responses.

I'd like to share with the Commission some relevant statistics that are more and directly - that are important and directly impact upon the youth, particular in the Bundaberg and Wide Bay–Burnett, Fraser Coast area. So the Bundaberg, Wide Bay–Burnett, Fraser Coast area, the median age is 46.7 years of age, but Queensland is 37.3. The median annual household income for the Wide Bay–Burnett, Fraser Coast is 58,930, whereas the Queensland state government median family income is 86,000.

Bundaberg has 33 per cent of households with a child under 15 years of age that do not have a parent or parents that have ever been employed. For the rest of the states, that's 24 per cent for Wide Bay, and for Queensland, 13.8 per cent. In many cases, those young people have never seen a parent get ready, prepared, and go to work. The state average percentage for young people completing Year 12 is almost 60 per cent, against 41 per cent for the Wide Bay-Burnett, Fraser Coast.

Given these few statistics, the Wide Bay–Burnett, Fraser Coast, and in particular, Bundaberg, could well be regarded as an area of disadvantage. The local community has a couple of fantastic programs I'd like to inform you of. One of these is accessible trial program, the Individual Placement Support.

PROF WHITEFORD: Sorry, IPS?

MR HYLAND: Yes, IPS.

PROF WHITEFORD: We're aware of that.

MR HYLAND: Yes, so the IPS. The other pilot program within secondary is called Link and Launch. Link and Launch is a pilot program that is being conducted within the six secondary schools in the Bundaberg area. The project is running for a period of three years and will complement and value-add the Individual Placement Support program, which has been trialled within 45 headspace centres.

Headspace Bundaberg has a close working relationship with the local secondary schools. Regular and consistent follow up for two years after leaving Year 12 is part of that Link and Launch program. In 2018, there were 662 students that completed Year 12. Of those 662, total of 143 had no plan for employment or plan for ongoing study after Year 12. Of those 143, 129 had never had any form of employment whilst at school. Given this, if young people gain some form of employment during the school years, they have a far better chance of securing employment after leaving school.

On September 10 2019, Angela Jackson from the Sydney Morning Herald reported that Prime Minister Scott Morrison noted the best form of welfare is a job. It is a widely understood and accepted fact that poor mental health or mental ill-health strongly correlates with high levels of unemployment and lower levels of education. The result is a greater burden on the health care and welfare systems, as well as the economic and productivity status of Australians.

Early intervention and the prevention of mental illness is vital to the entire socioeconomics of our nation. Prevention and early intervention of young people who experienced mental health issues, the adage is, a stitch in time saves nine is truly relevant, as we all know it is far easier and more cost-effective to prevent a crisis, as to deal with one. Therefore, the headspace model of early detection and early intervention really, really works.

The Individual Placement and Support Program, the IPS, which supports young people with mental ill-health to engage in work and study, is another successful trial program within headspace. From my perspective, and that of headspace national office, this program is a vital service that must be incorporated in all headspace centres.

Improving the mental health, particularly of young people, has a positive outcome for that young person, and the productivity and socioeconomics of the population, and I congratulate the Commission on also recommending this as part of their draft recommendations. Hopefully, for Bundaberg and district, headspace Bundaberg will be approved for an extremely - for this extremely successful program.

The Productivity Commission, in its draft report, acknowledged that 75 per cent of mental ill-health cases first appeared before the age of 25. Because of this, the Commission has prioritised prevention and early intervention as one of their five reform areas. I also congratulate them. There are a number of Commission recommendations that I would - that will have a positive impact on the mental health of Australians, and these include providing more outreach and mobile home treatment services for individuals experiencing mental ill-health, as alternatives to emergency departments.

Progressing the rollout of the Individual Placement Support program to support young people with mental ill-health engage in work and study. Strengthening our youth peer workforce and providing assertive follow up support for post-discharge after suicide attempt. However, I believe there are some missed opportunities within the draft report, some of which I will briefly touch upon.

The first one is a missed understanding of the strengths of headspace platforms, especially the

localisation of headspace centres, and how embedded they are in the local communities. Headspace Bundaberg, as with most centres, are created on the need and the groundswell of support from the local community, and concerned individuals and service organisations. This service was created by those people because of community needs. My centre was and still is driven by the voice of youth and the needs of the local community as identified.

The second point is, the extent of engagement with young people and their families - with young people and their families and friends. The prevention and early intervention of the young person's mental health is also greeted with benefit through the involvement of the family and friends. Headspace encourages the family and friends in the participation of the recovery, and provides opportunities for the young people to share their lived experiences in safe and supportive forums.

These forums include information sessions for the family and friends of the young people, allowing them to better understand the issues faced by the young person today. Family and friends are also included within the consortia, as they provide a perspective that has a great impact upon the young person. It is also important that the family and friends are also included in any discussions about youth mental health reforms, and that occurs through the consortia.

Given this, I strongly encourage the Commission to take up headspace's offer to meet with young people, their family and friends, and also the headspace clinicians. The third point is the significant impacts that the timing of the first onset of mental disorders in adolescence and early childhood can have on the young person's life. The transition between childhood and adulthood is a crucial time in a young person's life, and developmental periods for education, employment, and interpersonal and relational outcomes.

The timing of the first onset of mental disorders in adolescence and early adult can have a significant social and economic impact. It's at this age, and the stage in life that young people are, engaging in education that will have a formative - in their social connections and future pathways to employment, experience major life transitions, including moving between levels of education, from education to employment, away from their families and caregivers, into independent living arrangements. Developing and navigating new social connections and interpersonal relationships is also a point.

The last point I'd like to raise is the importance of reform for mental health to comprise youth mental health. Many of the recommendations in the draft report were framed around child and adolescent and adult age paradigms, and not youth mental health. However, it is imperative that any reform to mental health specifically comprise youth mental health. It is reiterated by young people who tell us they want the services that are youth friendly, recognisable and safe, which is why headspace is a service developed by and for young people aged between 12 and 25.

So, before summary, I would also like to voice my concern about the employment of suitably qualified professionals to work within the mental health sector. The Medicare Benefits Scheme provides the opportunity for psychologists, mental health social workers, and mental health occupational therapists to provide psychological interventions. Being a credentialled mental health nurse myself, credentialled mental health nurses are not included within that

Scheme.

I would like the Commission to note this and consider the inclusion of mental health - credentialled mental health nurses are provided under the same category. There is a number of very experienced credentialled mental health nurses not being utilised to their full potential. The hiring of allied health professional for access onto - or into an allied health professional for interventions under a mental health care plan is extremely difficult, and this would provide a welcome relief and addition of - a number of additional professionals.

I would again to thank the Productivity Commission for the opportunity to speak today, and applaud the Federal government for undertaking review. I would like to reiterate to the Commission that optimum mental health of young people is the key to the nation's productivity and economic success. The Productivity Commission is in a position of leverage for the voice of young Australians, so as to build upon the Federal government's investment in young people's mental health, including the headspace platform.

Finally, I would like to the Productivity Commission to work with headspace to engage with the diversity of young people who access headspace services to help inform the Commission to develop a final report, which is due in May 2020. In summary, I've highlighted the fact that mental health ill-health usually has its onset during the years between 10 and 24. Poor mental health has a detrimental impact on, and places huge pressures on, the health and welfare systems, and ultimately on the productivity and economic - economy of the nation.

Poor mental health is effectively addressed with early assessment and intervention, and headspace is the preferred and recognised youth specific service that works with young people at local areas. Thank you.

PROF KING: Thanks, Dean. If I can start off. I actually want to deal with - you touched on mental health nurses at the end.

MR HYLAND: Yes.

PROF KING: So let me start with that. So we've got a number of recommendations in our draft report around mental health nurses training. They seem to be one part of the workforce that we need an expansion in. We note the mental health nurses in GP clinics program that was funded and then defunded.

MR HYLAND: Yes.

PROF KING: But you mentioned the MBS, and I will confess I don't quite understand this. That mental health nurses (indistinct) almost every part of allied health keeps coming back to, well, if only we could get the MBS provider number, life would be good. And my reaction to that is, well, MBS provider numbers are fine for - if you're seeing specific services, and if you're not a GP, it's a service under a referral. But it seems to me to be a very narrow, activity-based or - not activity-based, but a fee-for-service funding scheme, and yet everyone says, well, we want to get on that.

Now, I do wonder, does everyone say, well, want to get on that because that's the only thing

that they see as available, versus other funding mechanisms. So I'd like to press you a bit on that. Why the MBS? Why not mental health nurses being funded through other support mechanisms, through contracting processes, through money going to - well, potentially GP clinics or to places like headspace? Why MBS provider numbers?

MR HYLAND: Well, my understanding is that, through the MBS, the (indistinct) and the previous services in GP clinics were funded through the Medicare Benefits Scheme. The issue that we have, and a lot of, I believe, a lot of the headspace centres have, and other - and probably GPs, is that whilst we have clinicians that can do the brief intervention and the assessment, a lot of those young people need a higher level of psychological intervention; CBT based, which can extend over, you know, five or six sessions.

Particularly in Bundaberg, we are limited in who we can actually refer to, and I hear this far and wide. And previously, as a clinical manager in Albury-Wodonga health, we had the similar situation where GPs didn't have the access to the allied health professionals because there weren't enough of them. So my understanding is this is another way of getting professionals, with a background and understanding of mental health, in to provide those services.

PROF KING: So do you see the mental health nurses providing psychological counselling type services?

MR HYLAND: The same service as what social workers and occupational therapists and psychologists.

PROF KING: Okay, okay. Yes, okay. Would that be the only area where mental health nurses - because I guess we were also looking at mental health nurses as things like care coordination. I guess we were thinking of them in a much broader role. Were we wrong to think about them that way?

MR HYLAND: No, look, I guess I'm biased, because I'm a registered nurse and then a credentialled mental health nurse. I believe that we have a greater understanding of medications, the physiological impact of mental health, and also from a bio psychosocial aspect. And this is in no way disregarding or lessening that of a psychologist or a social worker or an occupational therapist; they don't have the background or they don't have the understanding, the physiological understanding, in a lot of the cases that the nurses do have. So the majority of the allied health professionals work from a - not from a bio psychosocial, but a psychosocial aspect.

PROF WHITEFORD: Can I just follow up on one question while we're on nurses? So one of the recommendations in the report was around introducing a undergraduate mental health nurse qualification, and we've had different feedback from different, I guess, parts of the nursing sector, and from individual nurses about the pros and cons of that. I'd just be interested in your perspective about having that available for nurses, as well as a postgraduate qualification in mental health nursing.

MR HYLAND: They have the similar qualification for midwives. So I can't see why they wouldn't - or why they couldn't include that for mental health. It is a specialist area.

PROF WHITEFORD: Yes.

MR HYLAND: I've been fortunate enough to do my general nursing, and then postgrad studies in mental health and a couple of other areas, but I think it's vital, and primarily to understand from someone with a low prevalence disorder, if you had the opportunity to work within the acute sector, I think that expands your knowledge to community-based service provision too. So I think providing that undergraduate bachelor's degree is conducted within the acute care sector that involves the community also, I think - I can't see why that would not happen.

PROF WHITEFORD: Okay. I had one other question as well regarding - and jumping back to headspace now.

MR HYLAND: Yes.

PROF WHITEFORD: So, from your perspective, the role of referring to internet based therapies or online therapies, especially I guess for the people who might have challenges accessing face-to-face care as if - I guess in a timely way. Is that an experience you've had in the Bundaberg headspace, or in other headspaces or other areas you've worked?

MR HYLAND: So, telepsychiatry, which is access into a psychiatrist. We have all that services set up in our centre, but unfortunately, we don't have the referrals from the GPs. In the care of our young people, all our clinicians communicate directly with the primary caregiver, the GP, and if we believe that they would benefit from a psychiatric review, or the doctor understands that that might be appropriate, we always offer that opportunity.

But with the GPs at this stage, they would undertake that telepsychiatry review within their surgery. As a headspace centre, we need the referrals from the GPs to actually access the telepsychiatry, and ongoing for the telepsychology, if that's the case.

PROF WHITEFORD: What about online, internet based CBT, where it's not about seeing a psychiatrist or a psychologist, but doing some intensity - low intensity treatment on it.

MR HYLAND: We haven't had that experience. We've got six clinicians who are - can access clinicians. We've got one who is a trainer in Low Intensity CBT, which is fine. The rollout of that LICBT, are you sure - are you aware of that?

PROF WHITEFORD: Yes.

MR HYLAND: So I think that would be fantastic, but it's - from a centre manager's point of view, it's difficult to allow one of the clinicians, or two clinicians, to leave and be involved in the training, where, you know, we have all these young people accessing the service. What do we do? We say, hang on, we have to put you on hold until we get our people trained up, where they're actually educated well enough now to provide broad - broader CBT based interventions.

PROF KING: I want to step back a bit in terms of headspace, and how we should be

thinking about headspace. So headspace is an unusual group of services, if I can put it that way. Because headspace is both a gateway, it's a platform for other parties, such as GPs, psychologists, to provide services on. It co-provides services, and goes out and provides in-community services. You mentioned the Link and Launch program.

MR HYLAND: Well that's a part of the education system, not headspace.

PROF KING: Yes. Okay. It makes it difficult to think about exactly where headspace fits in, because if you're just a platform, a medical clinic which happens to rent out some rooms to GPs and psychologists, that's very different from an actual service provider, and that's different from a gateway that says, look, come in, we've got a national brand, we're recognised, we're a safe place. Come in for your primary health needs here.

And I must confess, I'm struggling with exactly how to think about headspace, and whether it's simply - should we just view it as an octopus that's sort of filled bits of the system because there's nothing else there. So I'm not saying it's a bad thing, but what should be the focus of headspace? What really should it be focusing on? You know, just in terms of Bundaberg, what's the key thing that headspace does that others can't do?

MR HYLAND: Because it's driven by the youth, it's a youth-friendly environment. So the youth of Bundaberg, they feel comfortable in coming into the centre.

PROF KING: Yes.

MR HYLAND: Now, with the stigma associated with mental health, or sexual health, or drug and alcohol, they come into the centre and no one knows where - who they're seeing. So, from that point of view, it's very confidential.

PROF KING: Yes.

MR HYLAND: So it allows them to come into the centre. It's their space. It's got great environment and it's youth-friendly and accessible.

PROF KING: So is it that doorway function that really matters? It's a doorway that people other - you know, if it wasn't there, the relevant young people would just fall through the gaps.

MR HYLAND: I believe so.

PROF KING: Yes, okay.

MR HYLAND: I believe so. The thing is, it's not just a shopfront.

PROF KING: No.

MR HYLAND: We don't have a GP. We have one allied health professional, because we can't get them. If we had a GP that was on there for one or two days a week, which I'm trying to do, and if we had more allied health professionals, the number of young people coming

through there would get a one-stop shop.

PROF KING: Yes.

MR HYLAND: We also work from a no wrong door policy, where everyone who enters the service, whether it's walk in or whether it's a phone referral or an email referral, we always refer them onto the most appropriate person or service.

PROF KING: Yes.

MR HYLAND: But the thing is, it's nationally recognised, and as I was saying in there, it's - young people feel comfortable coming in there because they know the service they're getting.

PROF KING: Yes.

MR HYLAND: Now, whether it's - a lot of young people, through adolescence, don't have a significant or a high prevalence disorder. A lot of this is stress related. The number of the young people that come to see us, the majority of those people, those young people, would be saying they feel validated, they're listened to, and within one or two sessions, then that stress is then dealt with. So it's not a roundabout that - providing the ongoing service all the time. It's around about having them feel comfortable coming into a place where they're non-judged, they're validated, they're listened to, and then they're given that support to be able to move onto the next part of their life.

PROF KING: Okay.

PROF WHITEFORD: One quick last question. Thank you for the time. The Indigenous workforce, do you have many Indigenous clients? Do you have cultural capability within the - your staff you're able to hire for headspace? How does that sort of work?

MR HYLAND: As I noted, I've only been in this headspace centre for eight months. It is building, and I think having the Indigenous workforce and Indigenous people coming into the service, it's around about building relationships. It's about building relationships with the Indigenous community. So that's what we're a part of at the moment. So once that's established, there are more and more young people, young Indigenous boys and girls, men and women, coming into the service, and that's through building those relationships.

PROF WHITEFORD: So just my interpretation of that would be that, in building that relationship with Indigenous communities in the sort of wider areas, important to them being comfortable accessing a headspace service.

MR HYLAND: It's no different than any other area. If people feel comfortable and they feel safe, and they're not judged, then they will come into the centre.

PROF WHITEFORD: Okay. Thank you very much.

PROF KING: Thank you, Dean.

MR HYLAND: All right. Thank you.

PROF WHITEFORD: Thanks.

PROF KING: Let's take a bit of a break for morning tea. There is enough food to feed an army at the back there. We've got five scones each, I think. And let's take a break for - a quarter to, let's come back. So about 20 minutes, a little bit under.

SHORT ADJOURNMENT

RESUMED

PROF KING: And thank you for chatting with us, Bronwyn. Just for the transcript, are you able to just state your name and the group you represent, and any opening comments that you'd like to make?

MS REES: Yes. My name is Bronwyn Rees. I'm actually here today with a support person, Anna Horn. I'm a developmental trauma advocate, and founder of Rise Above ACEs group, which is a Facebook group that we run raising awareness on the adverse childhood experience study.

PROF KING: Okay.

MS REES: A little bit about myself as an introduction, and how I came to be in this position. I come from lived experience of developmental trauma and adversity. I'm 54 years of age. At the age of 60, I decided to sign up for the Royal Commission into Institutionalised Sexual Abuse. At that point, I was able to access my records from New Zealand. The first school reports I read stated that, "Bronwyn Rees is a retard." That – straight away I said, "I told you there was something wrong with me, and I felt that my whole life." My whole life, I'd been in and out of counselling, trying to figure out what was wrong with me, only to be told I was strong.

I'm really sorry. This is where I think the massive file has come, because we're feeling creatures that think. The reason people reach out to go into counselling is because we don't feel right.

PROF KING: Yes.

MS REES: And a lot of the work that we are given is focused on CBT, which understanding brain science the way I do now, that part of the brain is not even functioning in a hypervigilant state. I've lived most of my life in that part of the brain. I've even had to learn how to breathe again, which I thought was amazing, learning how to breathe. Again, these things – if I knew all this information, I just can imagine what my life would have been like, how that would have impacted my own children. The domestic violence that I was in. What

I could have done to protect the transference of those fears, my fears onto my children, which I now see in them today.

PROF KING: Yes.

MS REES: The good news of all this was once I was told it was hardwired, that's really where my journey began. After doing a Diploma of Community Service, walking away again with so many unanswered questions and a lot of it just not making sense, I started research and work was (indistinct) schools. Dr Bruce Perry's Neurosequential model. The (indistinct) addiction. Dr Dan Siegel (indistinct) adolescence, which was really helpful for me, especially because three or four years ago I had a son who was stabbed. I was the way it was handled here. Trying to find support for him. Just every system, every service I approached, they failed my son, and to be honest, I am lucky he is alive and here today, and I believe 100 per cent that my son is with me today because of the information I had researched and was able to hand over to him.

Not long after his stabbing, I was able to tell my son that he may or may not have nightmares, flashbacks, those sorts of things. And it was like – I think it was about three or four months after the attack, he said, "Mum, I had the worst nightmare." He was able to come and talk to me about it, and we were able to have a conversation. I was able to then teach him how to be mindful of his thoughts, of his body, to be able to prepare him. He had many – I think it was five suicide attempts.

He was placed into hospital. On the last time, it was under police guard, they took him in, which I supported, again, to make sure that my son got the right help. The psychiatrist told him there and then, "We could hold you here," and he felt that he needed it, but all they could do was drug him until he said he didn't want to hurt himself anymore. And my son looked to me and he said, "Mum, this is not working. This isn't right," and I said, "I know, I know."

PROF KING: Yes.

MS REES: I'm happy to say that he is now an apprentice. He's completing – he's just completed his second year, going onto his third. And again, it wasn't because of our systems that supported him. I had to go overseas and find the help that I needed to be able to give my boy access. And the people that do know this information, I couldn't afford. So it's not available. It's not out there, it's not acceptable to us.

I think the hardest thing I've learnt since – like four years I've been researching. The hardest thing I think I've learnt in the four years is it's one thing to have all this knowledge, but then you need to be able to implement it. And to actually implement it, you need to have a safe environment.

PROF KING: Yes.

MS REES: Yes, trust, safety within our system and services. I still – I'm written up as noncompliant. That's not it, it's not that I'm noncompliant. It's that I don't get the support or the help that I need. I still struggle to this day.

PROF KING: Yes.

MS REES: I risk, you know – it's been a tough – a tough line (indistinct).

PROF KING: Okay.

MS REES: Have you heard of the ACE study, can I ask?

PROF KING: Sorry, I missed that, have - - -

MS REES: Have you heard of the ACE study, the adverse childhood experience study, done back in the late – 1998, I thought it is.

MR WHITEFORD: We have all that here. We have those studies, and similar ones that have been done on individuals who've been exposed to the adverse childhood experiences, and we've also spoken to - - -

MS REES: I think that, you know, the way I looked at the ACE study, you don't have to have ACEs to benefit from ACEs. ACEs is not a program, it is a mindset. It is a way of being. It is changing the way that we view people. You know, like if someone is having a go at me, I don't take on their behaviour as a personal attack on me. If anything, I stop and say, "Wow, what's going on in that person's life for them to be reacting the way that they are?" Because if I react to that, we're not getting anywhere.

PROF KING: Yes.

MS REES: If I try and – if I then wait until that person is back and regulated to their own – to baseline, I should say, we can then have that conversation and work problems out.

PROF KING: Can I just follow up on what you've just said there? Because I want to understand – so the system failed yourself and you said also the systems failed your son. But I want to understand exactly why. So did the system failures reflect that the relevant clinicians here weren't appropriately trained, they didn't understand the techniques?

MS REES: Yes. Yes.

PROF KING: Yes – oh, and/or, before you say yes, but and/or, is it also – was it that the clinicians here didn't actually have the right view of the people they were trying to help? I mean to what degree – was it both, or one or the other? Yes, I'd really like to understand why the system failed.

MS REES: (Indistinct) both of what you're saying there.

PROF KING: Yes.

MS REES: Lack of knowledge. This brain science is epigenetics, neuroscience, is fairly new.

PROF KING: Yes.

MS REES: So lack of information there. Now we're all talking about trauma reform, and I know people that have done the training through Blue Knot Foundation. Their services are now claimed to be trauma reformed. I've been in these services and I will guarantee you, they are not trauma reformed.

PROF KING: Okay.

MS REES: So what I'd like to see is how we can monitor our systems and our services to collaborate, collect data, and do you know what I mean?

PROF KING: Yes.

MS REES: When I say ACEs, understanding neuroscience and epigenetics gives you a different perspective. So you're not looking at the person as though they're the problem. Like my son's reactive behaviour, like he got threatened with being locked up and everything. And (indistinct) there it was just the kids acting from a place of fear, it's coming from fear, then act accordingly.

PROF KING: Yes.

MS REES: Don't threaten. Because you're just adding then to his already fearful state.

PROF KING: Yes.

MS REES: And the ACE questionnaire, what I like about the ACE questionnaire, it collects data, or a service is one, what they were using. It was to collect data to – hang on, just while I find it.

PROF KING: Yes.

MS REES: Page 1.

MR WHITEFORD: So while you're looking, can I just ask a question that will fit into this? So one of the issues that's been raised about the draft report we've released is that the recommendation for more trauma informed care needs to be built into the changes to the system. And what you're talking about would be consistent with that, is that what you're suggesting?

MS REES: Yes, definitely.

MR WHITEFORD: Yes.

MS REES: Definitely, but that's just part of it.

MR WHITEFORD: Yes.

MS REES: You also need to add in, we want trauma informed services. Yes, I support that 100 per cent. But without the ACEs science, epigenetics, neuroscience, the ACE study findings, the resilience, post-traumatic growth, without that added into it, you've only got half the picture.

PROF KING: So could you just talk about that a little bit more then? So what would have to happen to build that in as well?

MS REES: Training.

PROF KING: Training?

MS REES: Educate (indistinct).

PROF KING: Training of clinicians who work in the system, or - - -

MS REES: Anybody. Community. I'm all about community. Do you know, the best people who change behaviour are our parents. Parents deserve to know the largest public health discovery of our time, which I believe is the ACE study. They should have the opportunity to talk about their own life experiences and consider how they might like to use it, and use scientific discoveries to give their children greater health, safety, prosperity and happiness than they had. And I have been able to do that using the science of my own children, with clients that we have helped in the past, and I'm happy to say that everyone's doing okay.

We all have our down days, but we know that we'll get through it. We know that we've got support. We have a tool box of tools. I do, myself. Brain hacks of what I can use to be able to get myself through. It's not a deficit based approach, because it does not ask what's wrong with you. It asks what happened to you.

PROF KING: Yes.

MS REES: So at that point, you end up removing shame and blame. If you want to know why people don't engage, it's because of the shame and the blame. What plays out in our own head is not nice.

PROF KING: So can I ask a follow up question then? So are you aware of services either within Australia or overseas that do have in place those components you're recommending?

MS REES: I'm actually going to be meeting with the state government in the new year to discuss a partnership that I've been working on with ACEsConnection in America. Now on ACEsConnection, you've got access to any information you need. It's a support network for our judges to go to, for our schools to go to, for our services, for parents. Anything you want to know, resources. We do not have to reinvent the wheel here.

PROF KING: Yes.

MS REES: Like I said, I'm about communities, because I think each and every one of us can benefit from this work, and we might have to (indistinct words). Online training, I've done Alberta – the Brain Story Certification. Again, this information isn't available here in Australia, but luckily for me, I found a free online course, and yes, it was really a tough course to do, but I learned so much from it. I also did a (indistinct) on the ACEs training out of Iowa, again, online and free. So all this information is there.

I go on Facebook and I see groups of teachers, and the language used is shameful, it's the meaning. You can just see everybody is at breaking point. And then you go onto a trauma informed school site, where all the information being shared around, like the pages I'm connected to, it's full of hope of what works, you know?

Now we know the punnet of measures do not work. Jim Sporleder from Walla Walla High School, I'm in talks with him from Washington. He was the very first to implement this model using the ACEs (indistinct) in his high school. Now I can – I'm happy to say that after I think three years, there's no more expulsions. Better attendance obviously, and kids are actually with an average of 5.5 on the ACE data. They had a – they class school as home, family.

Now a lot of these kids, say myself, didn't have family support at home, so when we went to school, that's where we got our support. But if we're not getting the support there, where do you think these kids are getting support?

PROF KING: Yes, can I just pick up on that point, because you know, one of the issues with intergenerational trauma, making sure that we have a trauma informed, proper trauma informed care system, is where – you know, the point in a person's life where the intervention occurs. So my understanding of a lot of what you've been talking about, even at school level, in a sense it's - - -

MS REES: I'm really big on trauma aware schools. Dr Judith Power, QUT here at Queensland. She's written a draft on trauma informed schools, and it is brilliant. I actually am aware of the schools, Baringa State School. I'm in talks with Sharon Boland, who's the deputy principle. Again, very passionate about ACEs and they have implemented their trauma framework into their school, and I've been up there and I swear I walked out, one word, "calm". I've never walked into a school environment.

PROF KING: Yes.

MS REES: Now there's a child with special needs, and teacher can see by his behaviour, his body language, that he's not coping.

PROF KING: Yes.

MS REES: So they could call, and they've got a support person that steps in. "Hey little one, do you want to come for a walk?" And they go for a walk with them and you know, help regulate their emotions. So you're getting to them before they escalate to the state where you're unable to, you know, deescalate their mood.

MR WHITEFORD: Okay, understand that, but can I – because there's two - - -

MS REES: Sorry, (indistinct).

MR WHITEFORD: No, no. No, no. There's two issues though that relate to that. The first is if the trauma or the source of the trauma relates to the home, the family, then I guess – is having trauma informed schools enough if - - -

MS REES: No.

MR WHITEFORD: - - - the family – okay, so that's – so I'd like you to follow up on that. So perhaps if you can follow up on that, yes.

MS REES: GPs are our first point of call.

MR WHITEFORD: Yes.

MS REES: Now we're all going to go see the GP. I did a screening of a documentary called "resilient" at Queensland State Government, I think two years ago we did that, and it was my GP, Dr Danny – Danny – I can't remember his name.

MR WHITEFORD: That's all right.

MS REES: And my GP, he attended.

MR WHITEFORD: Yes.

MS REES: Now he works at a very – in a low socio group area. A lot of drug addiction and you know, dysfunctional families and stuff. After viewing this documentary on resilience, which highlights ACEs and the work that they're doing over there with this work. He actually said that he will now view his patients in a different light.

MR WHITEFORD: Yes.

MS REES: It's not – you know. Yes. Again, we want a two generation approach. So if GPs are taking the data, collecting this ACEs data, then you've got a bigger picture to write policy.

MR WHITEFORD: Okay.

MS REES: Do you know what I mean?

MR WHITEFORD: Yes.

MS REES: And I've got a lot of examples on how this data doesn't – sorry, the questionnaire – does not hurt us, it helps us.

MR WHITEFORD: Yes.

MS REES: I know for myself when I found out, I'm tenser. Since the original study, obviously more studies have occurred. And they've now added in historical trauma, which if we're talking about our First Nations, and I think we need to in a big way, historical trauma, epigenetics, there's our hope. Epigenetics is you turn on, turn off gene. It's very – it shapes who we are. And these memories, they're now scientifically proven, get transferred throughout the generations. And I truly believe if we were to change the conversation with our First Nations, especially our Aboriginal and Torres Strait Islanders, to something positive, to celebrate something that they already know and remove shame and blame, we're going to get decent results.

MR WHITEFORD: Yes.

MS REES: Like I'm Maori. I'm Maori descendent. And it was my culture that I'll hang onto, a belief, I really believe has kept me alive all these years, knowing that I – someone mothered me, it was my nana, my Maori nana.

MR WHITEFORD: Yes.

MS REES: I don't remember her, but I just knew that there's someone out there like me.

MR WHITEFORD: Yes.

MS REES: And that was enough.

PROF KING: Okay. Again, just on where – so you mentioned the GPs. How much do we also need to come back to sort of perinatal, you know, family support, again sort of thinking about the intervention as much as possible so that their – the trauma cycle is able to be held to - - -

MS REES: You're mitigating the harm.

PROF KING: Yes.

MS REES: Yes. Anything to (indistinct) those supports, and I've heard a lot of – I've been listening to a lot of the hearings, and I've heard some really good things happen there. But we do know that if we educate parents about their own ACEs, it helps them understand their lives, motivates them to learn becoming healthy parents to prevent passing (indistinct) onto their own kids.

PROF KING: Yes.

MS REES: Again, that's what I would say. If I knew this information, you don't think - like I knew I wanted to break cycles of violence, sexual abuse, alcohol and drug abuse, I needed to break those cycles and I have done. But what I didn't know was my fears, that that is what I transfer onto my children but, again, with this knowledge, I'm able to help them.

PROF KING: Yes, all right. I think I've covered off on pretty much everything.

PROF WHITEFORD: Anything else, Bronwyn, you wanted to mention to us before we - -
-

PROF KING: We finish up.

PROF WHITEFORD: - - - finish up and thank you for your time?

MS REES: Well, we're talking about is CBT and I really want us to get a grip on the importance of your own science, epigenetics and body. You know, we carry our trauma in our bodies so why aren't we working with the body, incorporating that into school programs and knowing what stimulates the brain and what doesn't stimulate the brain (indistinct). Do you know what I mean?

PROF WHITEFORD: Yes.

PROF KING: Yes. Just as a matter of interest, from your perspective, I mean we know CBT's the wrong therapy trauma I mean it just doesn't work but it's not meant to work for trauma. So there's alternative therapies such as - one's called EMDR, I'm not a therapist so I'm not going to try and remember the others but - - -

MS REES: You know, NDR, (indistinct), yoga, dance, anything to do with movement. You're actually realigning your body. So people ask me, I just say, 'Mate, jump around'; yawn is another (indistinct words).

PROF KING: So it's those sort of, you know, mind, body-based therapies that you found are the ones that work or the ones that are useful?

MS REES: The ones that helped me, yes, definitely.

PROF KING: Okay.

MS REES: Just telling me to get over something doesn't work because I don't feel it.

PROF WHITEFORD: Yes, that doesn't work.

MS REES: Like, rationally, I know when I'm triggered. Like, as an example I was on Facebook and I shared a picture of one of my children's birthday. I put it up as a header; their dad found me. I've been in hiding for many years. He'd found me and sent a message. I quickly jumped up, ran around the house, locked every window and sat in a corner shaking. He was nowhere near me and yet, my body reacted to it.

PROF KING: Yes.

MS REES: I had my grandson with me the other day; now that was me then, this is me today. Yes, so Friday I had my grandson with me and he was unwell. He'd come up with a rash, I'd rung his mum because I'm a bit worried. She said, 'Go to a chemist,' I went to a doctor. They were there, so I went straight into the doctor, they said, yes, he needed to be

seen straight away. My anxieties kicked in and I'm now not coping. The receptionist had said to me, 'You've got to fill out this form.' That part of my brain has switched off, I'm now in survival brain. So all I'm seeing is lots of words and nothing's making sense and I said to the receptionist, 'I need help. I can't do this.'

And whilst holding my grandson - this is how this work helps you - I'm that body aware that I felt the energy of my grandson drain because he was now picking up on my energy, which was chaotic. I knew at that point I had to step back and this is what I mean. This is how we can help our children and I knew I had to step back. So I stepped back, I rang mum and I said, 'Mum, talk to reception about the paperwork,' which they did. I was able to walk with my grandson saying, 'It's okay, bub,' you know, and work with him. Within seconds, his energy levels picked up and he was okay. Turns out he was fine; we got the medication into him and we avoided anything that went wrong.

PROF KING: Yes.

MS REES: But that's an example of how quick we can become reactive. I think for me, it's about a better quality of life, this information, but if we can get to people at a younger age with neuroplasticity, our brains do want to heal, we can rewire their brain; inspire to rewire. Neurons that fire together, wire together and again, repeat, repeat, repeat. You cannot have this information without keep on doing it. So the final thing I want to say today is my aim is to get out there, educate every person and every organisation about ACEs Science 101, how people and organisations integrate healing and to trauma-informed practices (indistinct) their families, their organisation, system and the communities in which they live.

Secondly, to aggregate, gather data such as a number of (indistinct), the number of organisations that are becoming trauma-informed and the resulting outcome in organisations and sectors, such as (indistinct), less absenteeism and less teacher turnover in schools as an example. Engage; engaging with people and organisations to join the local ACEs initiative. Little bit or a lot; any involvement is good; and fourth, to activate people and organisations to commit to integrating trauma-informed and resilience building practices in their personal, family, volunteer work and community lives. This heals systems and community.

And not to forget and celebrate any accomplishment ACEs summit, Community Resilience Day, Proclamation, post anything large or small that your community is doing on our website or hopefully the partnership that we're going to be setting up with ACEs Connection in America.

I know a lot of what you're discussing is really yucky and horrible, but once you start celebrating neuroscience and the hope with the resilience building work people, especially us parents, we want this information and it's amazing what we the people can do with it. But we can't do anything because we don't know about it. So expecting us to change isn't going to happen. We need this information and I'm hoping this report will (indistinct).

PROF KING: All right. Thank you so much, Bronwyn. That's been fantastic, so thank you for talking with us today.

MS REES: I'm happy to send through some information.

PROF WHITEFORD: Yes, please.

PROF KING: Thank you, Bronwyn. Thanks for doing on a day that probably wasn't your best day. So we really appreciate you being able to do that.

MS REES: Thank you. I just wanted to be heard, and I'm sorry, after what I've been listening to - yes, another thing. I've heard a lot of people worry about money. You've got counsellors wanting wages and TED support and I'm like, 'This is crazy.' There are so many services out there that I'm really afraid of because I know what they're doing and the ACEs work especially, and trauma and (indistinct) work, if not done properly, it can cause more harm than do good.

PROF KING: Yes, okay.

MS REES: And I will be watching like a hawk because I'm very passionate in this place and I'm not going to go quiet because, I don't know, it's lifesaving (indistinct).

PROF KING: All right, thanks, Bronwyn.

PROF WHITEFORD: Thanks, Bronwyn.

MS REES: You're welcome, thank you.

PROF KING: Bye.

MS REES: Bye-bye.

PROF KING: Jenny. Thank you, Jenny, brilliant.

MS SMITH: Yes.

PROF KING: And for the transcript, Jenny, you can just state your name, the organisation you're representing and any opening comments you'd like to make.

MS SMITH: Yes, thank you very much. I'm Jenny Smith. I coordinate the mental health programs for Anglicare throughout Central Queensland in the central west. I would like to start by saying thank you for coming to our regional areas. Very much appreciated, as well as all the information that's included in the reports, I think your presence here speaks louder than a whole lot of other things; so I would like to say thank you.

Just to give a little bit of my own stuff, I've been working in rural and remote communities and across Central Queensland - I've actually travelled from Spring shore this morning. So I work in those communities because I believe that rural communities need a voice.

So I have three areas that I would really like to really emphasise to the Commission and regarding the report. One, is don't underrate the importance of community non-government

services in the mental health system. Often the non-govt services, the community services are the services that are consistent, particularly in rural and remote areas.

Those services have been around along time, whereas some of our clinical services are constantly changing staff, constantly changing practices and the community services do a great job, and I know, speaking for not only Anglicare, but my other colleagues in other non-govt services, they work really, really hard and are passionate about supporting people with mental health. So that's one thing I just wanted to say around that.

One thing for people that we've discovered - so I've worked in this journey now for 20 years. I've worked with people with mental health for 20 years. The first I guess 10 of that was clearly around being a clinician and providing services and supporting people. I've endeavoured in the last 10 years to get into this wonderful space called the recovery space and for me, the journey for people with mental illness, travels from that intense space, building on their strengths, into being able to join groups and that has been phenomenal. Groups, inclusion, social inclusion, building their life skills, building their psychosocial skills, having the psychoeducational groups, have made an enormous difference and we have a variety of those groups that we offer including - and just listening to the lady Bronwyn in the previous conversation, very much about that sensory development to help with trauma-inform.

The emotion release in a safe way, in a safe space and some of the groups we find work really well, from our point of view, are the creative expression. Just people being able to release those emotions. Obviously the normal skill groups like cooking, budgeting, personal care, they're very, very important. But the one that I would really like to emphasise that we've travelled in the space over the last three years is DBT, and we recognised as an organisation, that there are a lot of people falling through the gaps in our services, in Central Queensland and in the west.

And in terms of falling through the services, I'm talking about primarily I guess people who have substance abuse or comorbidities around that or dual diagnosis around that and use substances as a way to self-medicate. And also, in addition to that, people who fall into the diagnostic categories of personality disorders.

So because there are limited resources in our areas, and the resources are changing, we were finding there were a whole group of people that were burning out services; they were burning bridges because - - -

PROF WHITEFORD: So the clients were burning out or the staff were burning out?

MS SMITH: Both, really, because the clients were having a voice: 'I want you to hear me, you're not hearing me. You're not giving me what I need to move forward.' You know, people in crisis, and particularly around personality disorders in crisis, can be very, very demanding and that's no disrespect. It speaks of the trauma that they've experienced.

So we got ourselves trained in DBT and have since, we've had approximately 120 people over the last three years in a very small service that have engaged in this DBT skill building - we don't call it therapy, we call it skill building.

PROF KING: Yes.

MS SMITH: And the results have been phenomenal. There's 80-odd per cent of people that have expressed feeling better about the world and it's the information and skills that they learn. Because, obviously, CBT is one of the preferred - I've lost my train of thought there. CBT is one of the things that's offered.

PROF KING: Yes.

MS SMITH: So when we offered DBT, just as an example just to highlight what I'm trying to say, I did some evaluation with the people, I did a (indistinct) with the people and I said, 'Was this successful? Is it worth us pursuing this?' - this is in the earlier days - and the young woman who was 25 said to me, 'I have been having CBT since I was 13 and I knew I had to change. But what DBT has taught me is the skills to use to change behaviours.'

So we built on that and unfortunately we don't have the resources to do really robust evaluations, and I would love to do that. But the feedback from people is they've engaged in employment, they've engaged in - and these are people that have been in the system for very long periods - they've engaged in employment, they've engaged in establishing relationships, they've engaged in education, their spark for wanting more information has been lit and they've continued on, and a very high thing, is we've been able to keep people from repeat hospitalisation.

PROF WHITEFORD: Can I just ask a quick question before I lose the train of thought? How long did it take you to train the staff in the DBT?

MS SMITH: We were already working in it but we got a trainer up and it was - I already have skilled staff in mental health.

PROF KING: Right.

MS SMITH: So we got this trainer up for a week to really work to further develop that training, some of our staff actually engaged in a year long training process through Sydney.

PROF KING: When you say, 'Trained staff,' so would they have psychology backgrounds? Would they have nursing background? What sort of training are we talking?

MS SMITH: We have some with psychology backgrounds, a number with social work backgrounds, a number who are lived experience peer workers who have engaged in formal education.

PROF KING: Yes.

MS SMITH: We have people who are teachers, we have people who are nurses and we have people on the road to learning. We have people who have worked in the industry for 20 years and have a real handle on mental health.

PROF KING: Sorry, I will let you finish your opening comments in a second, but we've taken a slight detour. One of the things that - and I'm not a clinician, I'm not psychologist, you know, I'm not an economist who's coming from outside.

MS SMITH: No.

PROF KING: One of the things that sort of strikes me in this area is there are a range of therapies and that work for different issues. So CBT fine for I think it's mild depression; it's really good.

MS SMITH: And anxiety.

PROF KING: And anxiety. DBT is more aimed at personality disorders; EMDR, which I mentioned earlier on, is very much for trauma.

MS SMITH: Trauma.

PROF KING: To what degree do you need - okay, so let me step back. You mentioned - CBT's come up a few times and it seems like - well, someone overseas is going, 'Let's train everyone up to do CBT and basic CBT'

MS SMITH: And low intensity CBT.

PROF KING: Yes, but as an outsider coming in, it sort of strikes me what we actually need is a workforce who either there's somebody there who's able to say, 'Well, you need this sort of therapy or this is the direction.' Or you need people who are able to deliver the right sort of therapy to the right person because - so when you say you trained up the workforce to DBT that sort of sends the alarm bells ringing because I think, well, what happens if someone comes to use your service where it isn't there?

MS SMITH: That isn't the only - - -

PROF KING: So can you try and clarify it ?

MS SMITH: Sorry, that isn't the only thing.

PROF KING: Yes.

MS SMITH: So when a person comes in - perhaps, I better just highlight the journey - shall I highlight the journey?

PROF KING: Yes, please, that'd be fantastic.

MS SMITH: I want to say, between 85 and 92 per cent of an outcome for a person entering the service is their engagement with their worker and, to us, that's crucial.

PROF KING: Yes.

MS SMITH: So a person comes in; they're referred into the service or whichever way the referral pathway is, it isn't about, 'You'll do this therapy,' it is about, 'Who are you? What is it you want? What is your experience? Can you talk to us about what are your strengths, where you're going?'

So there's a whole process around this and it's identifying people's strengths, working with people around (indistinct) domain and that's about sharing the conversations.

PROF KING: Yes.

MS SMITH: Having the conversations, finding out where they are. When they build a rapport, 'What are your goals in life?'

PROF KING: Yes.

MS SMITH: 'What is your vision for you? What is your vision?' If I saw you as someone who has incredible sense of wellbeing, emotional, physical, psychological, spiritual, 'What would I see that I'm not seeing now?'

PROF KING: Yes.

MS SMITH: And it's about that conversation goes. People's goals are highlighted and then those therapies are offered as an option.

PROF KING: Okay.

MS SMITH: 'Would you like to explore this?' or you work with someone for three months to get them in a safe space. You don't give any therapy when people first enter because generally they're in a crisis state. They're not ready to hear anything, so you (indistinct) capacity within the service, within themselves to be able to be open to receiving therapies.

PROF KING: Yes.

MS SMITH: And I think that's a mistake that we make, and I would say - probably I'm talking out of school here - - -

PROF KING: No.

MS SMITH: But in terms of have better access in our psychological therapies and this, I think it's a huge mistake because the first port of call is let's put them into a psychologist. You're wasting the person's time and another sense of failure because they're not able to engage in that therapy.

PROF KING: Yes.

MS SMITH: Does that make sense?

PROF KING: Yes; no, it does.

MS SMITH: Yes, so it is about there's a time for more intense therapy, but it isn't as the first port of call, even if you can get (indistinct) in your report you say, 'there's lots of psychologists in Australia,' I'd like to invite them into the rural areas if they would like to come; we would look after them.

PROF KING: There is a mill distribution; Melbourne, Sydney corridor and Brisbane. Lots of psychologists but, yes, not elsewhere.

MS SMITH: We're fighting all the time for psychologists. 'Please, come, we're very nice people.'

PROF KING: Anyway, we're in the right (indistinct).

MS SMITH: Yes, so in terms of that, our journey with people isn't about what we think or we assess as being what they need or what they want, it's what they identify as ambition for wellbeing.

PROF KING: Okay, sorry, now, we interrupted your opening comments (indistinct).

MS SMITH: No, that's okay.

PROF WHITEFORD: Anything else?

MS SMITH: Yes, so (indistinct) you know, you can work with someone on an individual basis, but when they feel safe enough and ready enough to join in a group. That's when you see recovery (indistinct).

PROF KING: And social inclusion.

MS SMITH: And social inclusion.

PROF WHITEFORD: So what are the pathways into social inclusion, do you think? So what do you know just from the services you get involved in that work to get these people back into - not I guess into mainstream, but into pathways that work for them rather than just the pathways that, you know, everybody knows about or whatever.

MS SMITH: In my grey-headed experience the first thing is to get them feeling safe and a little bit confident in themselves. When you do that, and I suppose in that is that trust building in the service relationship, and then we're asking people to get a little bit out of their comfort zone. Let's try the group stuff and peer workforce are amazing in helping people move forward with that one.

PROF KING: (Indistinct).

MS SMITH: They're just amazing in giving people the confidence to give it a go and then, once you get them into the groups, social inclusion first; they start to meet other people. And just as an example of that, I had one woman, personal disorder, really, really, in the systems

for many years, and I said to her, 'Could you just try this group?' She went and she come sobbing and I thought, 'Geez, I made the wrong mistake there.' But what it turned out, that was the first time in her life she'd met someone that had the same thing. So for her, that was a new experience and she's gone on to bigger and better things now.

PROF KING: Yes.

MS SMITH: And social inclusion is trying to reconnect with family members that have been disengaged because of the illness and try and connect with those support networks and mediate those support networks to, you know, educate the people in those support networks to be able to then support people and, yes, people do come into the mainstream as well, when they feel safe enough.

PROF KING: So say, somebody with a borderline personality disorder probably not employed, maybe having trouble maintaining housing. We've talked a lot about, in a sense, the community/quossie clinical side, if I can call it that. But do we really need a team support around that individual because there's a whole bunch of other things happening in their lives as well. How does somebody like them (indistinct)?

MS SMITH: Often people become overwhelmed with a whole lot of people in their lives and I think that's where we try to coordinate that and work with them to see with they're at, so they're not overwhelmed, that we can navigate when it's a safe time for them to navigate.

PROF KING: Okay, yes.

MS SMITH: Yes, but generally, you know, you do need a number of people around. You need that clinical for the suicidal times and that's why it's really important for us to have a close relationship with our clinical colleagues to be able to, in times when it's beyond the capacity of community, to handle this is to work with the colleagues.

PROF KING: Because we did emphasise in our report importance of that team-based care.

MS SMITH: Absolutely. PIR was a wonderful example.

PROF KING: Yes.

MS SMITH: PIR was a great example of coordination and being able to - because the support facilitators were the constant in that person's life and the outcomes change when you get everyone on the same page at the same table.

PROF KING: And truly having that constant. I mean we've been accused of reinventing PIR which is sort of true.

MS SMITH: No, well, you agree with me. But I mean whatever you call it that is certainly I think is that coordination.

PROF KING: The key or a key element, yes.

MS SMITH: But even with PIR, because we had a few facilitators in PIR, we didn't know enough about coordination. We didn't get enough of the substance of coordination. We've learnt more as NDIS has come in about coordination so we'd get people sitting at the same table. But I think we've build a lot of skills around coordination now.

PROF KING: So what are the extra skills you think are being built?

MS SMITH: I think a lot of it with PIR - and you'll know this at the beginning - a lot of it at PIR it was seen as, 'We need services. We don't need anyone to coordinate us,' so there wasn't that respect.

PROF KING: Okay.

MS SMITH: So for the first three years of PIR it was people feeling confident within their own practice to be able to say, 'Well, no, Dr Such and such, this is what we're seeing. I'm wondering if you can come with us and help us achieve this for Jenny.' You know, so that's what we see with - that's why I think it's phenomenal.

PROF KING: Yes.

PROF WHITEFORD: So the skills we've got is confidence, more knowledge about, you know, coordinating supports and more traction in the space, more validation in the space.

PROF KING: Yes, okay, are there barriers to the involvement of consumers in carers that we could, you know, consider; we could make recommendations?

MS SMITH: Absolutely.

PROF WHITEFORD: Well, what would change to make that involvement, you know, better from your perspective?

MS SMITH: Constantly have carers talking, well, through our processes we - in one of our previous things, carers were one of our groups that we worked with. Unfortunately they've been left out in the cold with it now, but carers, they feel the system lets them down; they're not heard, that collateral information isn't taken seriously enough.

PROF WHITEFORD: Yes.

MS SMITH: So I have two workers that have people who are - and they're both social workers - and ones a social worker and ones a triple degree psychology social worker. Now, they both have children who are, perhaps, severe and persistent mental illness. Now, they say it doesn't matter that they work in the industry and that they're degreed in this; they're not listened to.

PROF WHITEFORD: Yes.

MS SMITH: So systems will, if the person's in the in-patient unit, they're training the people in the in-patient units how to manage their person.

PROF WHITEFORD: Sorry, so can I just clarify and make sure I understood what you've just said. So those individuals are training the clinicians who work in the in-patient units, so they're coming from the perspective of carers.

MS SMITH: Yes, and who know that person; who know that.

PROF WHITEFORD: Okay.

MS SMITH: So if someone's tearing their hair and feared, 'Oh, he thinks he's got spiders in his hair.' 'Oh, has he?' but at times - - -

PROF WHITEFORD: Sorry, when you say, 'Training,' you do mean formally training or just - - -

MS SMITH: No, no, I meant - - -

PROF WHITEFORD: Yes, just to clarify.

MS SMITH: Informally giving information that will support that person's care whilst in the in-patient unit.

PROF WHITEFORD: Informally in their role of carers, yes. But is it recognised the service?

MS SMITH: No.

PROF WHITEFORD: So part of what we do is bring carers in to help our staff understand.

MS SMITH: Beautiful; that would be really positive, but just let them - - -

PROF WHITEFORD: Right.

MS SMITH: And we know there's sometimes carers who are overprotective; we know that. But surely as professionals, we can manage that and bring them with us. But there's a lot of times, and I think one of the carers said to me, 'I don't know where to go next. I have just got my son to talk with the psychiatrist and he said, "Well, you know terrorists are a problem."' So for them, it is. We've got a long way to go culturally, but it's exciting that we're at the beginning of the journey in that way I think.

PROF WHITEFORD: Yes, okay.

MS SMITH: Carers are people; they're an invaluable resource.

PROF WHITEFORD: Yes.

MS SMITH: So, you know, like, for example one of the sons of one of the women that I'm working with, tomorrow is giving a talk to staff by digital stuff to help us understand the

space and what we need to be mindful of. High functioning, (indistinct) international business man.

PROF KING: Just one final question from me. You mentioned peer workers before, and we've got some recommendations about, you know, representative organisations for peer workers, helping them, you know, get a part because sometimes peer workers are viewed, well, they're an untrained voluntary workforce, and we want to move away from that because they're a lot more valuable than that.

MS SMITH: Yes, absolutely.

PROF KING: But have you hat any suggestions on how we can do - - -

MS SMITH: I have. I've just dipped my toe into this in the last two years, to be honest, and I did it with great trepidation.

PROF KING: Yes.

MS SMITH: Not because I don't think - I know the value, but I was making sure that our organisation could support these people and that's one of the things. So we've just employed a further six peer workers in our organisation, so about 20 staff for mental health in our organisation. I think it's 11 are lived experience.

PROF KING: Yes.

MS SMITH: And the recommendations I would make is help us do the right job. Help us not go down previous historical paths where we devalue people or we're not inclusive enough of the experience. What are the support needs that may be different for peer workers? You know, workers that identify as being well emotionally.

PROF KING: Yes.

MS SMITH: Because we don't call the peer workers, we call them living experience workers because they're still living every day with their mental illness, even though they're functioning beautifully.

PROF KING: Yes.

MS SMITH: So the recommendation is help us; help us do it right. Give us - you know, like, you've got the ability to do all of the research and we've just engaged in the Queensland Mental Health Commission of Peer Support Framework.

PROF KING: Yes.

MS SMITH: So we're using that as a guiding document. But it's great in the strategic level, but it's not great in details.

PROF KING: Yes.

MS SMITH: What do we need to be careful of? So I've engaged with other peer-led organisations to help. So if you as a commission and in a position where you can really influence - and you are obviously - but influences; help organisations do the right thing by the people (indistinct) I think, yes.

PROF KING: Okay.

MS SMITH: So we need education for organisations.

PROF KING: Yes.

MS SMITH: And for me, I'm still flying a bit blind here, with good intent, but I want that good intent to be okay and safe.

PROF KING: Okay.

MS SMITH: And that is, how do I help my organisation engage in that.

PROF KING: All right, thank you.

MS SMITH: And detailed guidelines around that would be - - -

PROF KING: Yes.

MS SMITH: Is that enough?

PROF KING: Yes.

PROF WHITEFORD: We understand. So that's all?

PROF KING: Thank you very much, Jane. It's been brilliant.

MS SMITH: Thank you. I just wanted to say, I know NDIS isn't part of this, but in rural areas it is the best rural, you know, social reform of our era. It is just fantastic, but we've still got a way to go with mental health; you know that.

PROF WHITEFORD: Indeed.

PROF KING: Yes.

MS SMITH: Because people with mental health that we've help transition through PIR are now wanting to re-engage with us because their mental health is deteriorating because their support workers aren't being trained.

PROF WHITEFORD: Yes.

MS SMITH: Thank you.

PROF KING: Thank you to you.

MS SMITH: I really appreciate your time.

PROF KING: No, thank you, Jenny. That's been fantastic. Belinda, so, please, come and sit.

MS CHELIUS: Yes.

PROF KING: If you could state your name, organisation you represent and any opening comments that you'd like to make for us, Belinda.

MS CHELIUS: My name is Belinda Chelius. I'm the General Manager for Eating Disorders Queensland. So we are a state-wide funded service by Queensland Health. So there's a hope that we do state-wide delivery but of course, the bucket of money doesn't extend completely state-wide, but we do aim.

So my conversation would've been a little bit around rural and remote support and I'm not going to speak about a specialist field, but prior to being the general manager, I worked in other NGOs across mental health and of course, PIR, I've got extensive experience in running it and been overseeing PIR and that was probably my opening statement that I wanted to make because the report talks about care coordination. We invested a lot of money in Partners in Recovery. I think it was the biggest expenditure yet, that Australia did.

Why? Why has it gone? It worked exceptionally well, especially in the PHNs that I had the privilege of working with, which is Brisbane North, exceptional consortia, exceptional ways of working together. The training, the systems reform that came out of that on grass root levels, not just the higher systemic reforms because they had a little bit of brokerage money for systems reform.

And, you know, even having brokerage money, we found we didn't use a lot of that money. We could do a lot with a little bit of money and getting not to present at hospitals. I know that's just my biggest surprise, that PIR and all that amazing resources, that resort, the data we collected through PIR, it's like a wealth. Where's it gone? Why did we waste that money? That, to me, is just unfathomable.

PROF KING: Can I just ask a follow up question on that?

MS CHELIUS: Yes.

PROF KING: So we understood that the money that was for PIR went to NDIS.

MS CHELIUS: Yes; NDIS.

PROF KING: Yes, but the PHNs were then given money to replace some of that work.

MS CHELIUS: Yes, but it was not the same level.

PROF KING: Okay.

MS CHELIUS: So what PIR now - I'm not involved with PIR anymore, but I know purely, they were transitioning people into NDIS.

PROF KING: Right.

MS CHELIUS: So what that meant, it's psychosocial support, but people with mental health concerns, we know they aren't always eligible for NDIS so it's a small percentage of that clientele that get into NDIS so what happened to the others that aren't eligible for NDIS? So we know the PHaMs program also was absorbed into NDIS. There needs to be a rejig of that because people keep talking about care coordination and I'm, like, 'Hello, we've done it. We've done a lot of it. We've got lots of research. Why do we do the same things'. I'm just a little bit - unless I don't have the bigger picture but I've worked around this track - - -

PROF KING: No, I don't think you're the only one. We've had - just every public hearing just to that we've been told the same story.

MS CHELIUS: Yes. Okay, great. Because I worked initially in setting it up and I oversaw quite a few PIRs across PHNs and it works. Mike Butler had a great idea at work, like, - - -

PROF KING: Can I just before we - - -

MS CHELIUS: Before we get into eating disorders.

PROF KING: Get into eating disorders, yes. Can I just ask why do you think - what was the key for PIR working as well it did? What were the core elements? If you were saying, 'Look, yes, we could do it again. These are the three things you need to make sure you have to get the benefits that we got out of PIR'; what would they be? What are the core elements?

MS CHELIUS: Work has been bettered in organisations that worked with clients who already trusted them.

PROF KING: Yes.

MS CHELIUS: They weren't an extension of HHS or the emergency departments, there was initially - obviously when everyone went for the funding there was a competitive - because we know that tendering makes us all competitive and put us against each other - and then we coped well together; but that's fine. With PIR, once we had the funding it created a collaboration. My organisation didn't do AOD and I knew that, organisationed it, referral pathways.

PROF KING: Yes.

MS CHELIUS: We actually got to know who the services were. Just like the clients who struggle navigating the system so do the workers so we actually started to get to know each other, where do send people, so that was really, really, important and having a good PHN.

Having a PHN that's involved, that gives resources, training, that was the core and I worked across a few PHNs and Brisbane North was by far an outstanding of how we work together and the organisations that tendered and got part of the consortia but it was very good with PHN Brisbane, and the staff.

There was a new way for innovation so we found out that the LGBTI community needed a PIR worker so we could give up some on your positions (indistinct words) get a worker and the same with RYUI, an indigenous organisation, they did it. PIR, so some of the big consortia members gave up FTE to give to other organisations so there was a bit of inflexibility in that whole tendering process.

PROF KING: Yes. Eating disorders.

MS CHELIUS: Eating disorders, the passion where I'm - why I'm here. It's like I say we're state wide service so rural and remote areas, it's an issue for us.

PROF KING: Yes.

MS CHELIUS: Queensland Health acknowledges that but of course it's the bucket of money and it's state funding versus federal funding so that's that gap again. If you've got state funding, the feds are not going to look at you - just because you've got a big overall and remote area that you've got to cover so we do look at Telehealth but I think there needs to be a better government approach - support for NGOs at around Telehealth so right now I will purchase Zoom, do Zoom with clients in regional remote areas but I think we need something a little bit more sophisticated and Telehealth, there's the Telehealth platform but Queensland hasn't signed up to that one so again some states sign up to some things, some states don't, so.

PROF KING: Do you find the Telehealth effective?

MS CHELIUS: Yes, so especially for disorders because it's such a specialist field and a lot of your - even in urban areas your clinicians are reluctant to go there so we find for our cohort we would like to see something of them initially because there's a big medical crisis attached to that but obviously it's not always possible but for us it does work.

PROF KING: Yes.

MS CHELIUS: Yes, it does. It's not the same. Because our organisation offers so much more than just the one on one, you know, recovery is not just (indistinct words), it's about relationships, it's about communities, it's about engagement so as rural and remote is a real struggle.

PROF KING: Yes.

MS CHELIUS: And like I said it's not like Queensland Health doesn't know that but it's hard - and we also find for us as an organisation based on Brisbane, to come into rural remote areas sometimes I could get a grant, for example, to do groups in Toowoomba but because the community doesn't know us we found it a real struggle to actually get people to engage with us.

PROF KING: Okay.

MS CHELIUS: Because we're not local.

PROF KING: Yes.

MS CHELIUS: They don't know us. 'Who are you? Where are you from?'

PROF KING: So both the clinical and the community based - - -

MS CHELIUS: Yes, yes, so I would go to HHS and they said, 'We've got a lot of patients, inpatient', we can get them' - okay, eating disorders is something anyone wants to admit to but we just find - yes, we just don't have the capacity to be on the ground all the time because the communities trust who they have in their communities so our best way of getting in to communities were through the schools. They were very, very, very successful, exceptionally successful.

PROF KING: Okay. What do you do in this course?

MS CHELIUS: So do early intervention prevention, we don't talk eating disorders in schools, we go in and educate around weight stigma, diet culture, social media, media literacy and we try and pre-empt a lot of cultures that live in an eating disorder especially how people are perceived; how you should look, what you should wear, and also the - and unfortunately that still happens in school education, there's a morality around good and bad foods, there's - you know, if you look a certain way you're successful and it's the diet culture so that's what we do in schools is actually going in and giving young people and the school-based nurses or the counsellors at the school a different language to use around food and around health. Health is not just about clean eating and not eating sugar.

PROF KING: So is the program to the students or to the teachers?

MS CHELIUS: So the teachers usually come to us and ask us to come into the schools but I think the way we've designed it it actually touches across all of them. The teachers will come and say, 'We've learnt from that' so we're just working with QUT now to get it really embedded and evaluated and rolling out and creating a bit of that peer mentoring and you've mentioned that in the report. You're not choosing leaders in the schools.

PROF KING: Yes.

MS CHELIUS: And Butterfly Foundation has done that too and it works really, really well and I think that's how we can get into remote and rural communities to start trusting us, this is the school-based ones. Once you're in a full blown eating disorder my feeling is it's a different approach, it's different.

PROF KING: Well, how well do the GPs play their role of recognising eating disorders, knowing what services are needed for the person; so are GPs effective or not?

MS CHELIUS: It's a hard one. Yes, so in Brisbane we've got I can count on one hand the GPs we use. We are main NGO funded by Queensland Health so most of the people - it's a step down approach; come from hospital, go through to (indistinct words), comes to us. A handful who feels comfortable working with people with eating disorders. We have a lot of stigma attached to that and I think we put a lot of burden on RGPs, our general practitioners, and notes all about going to your GP. I think RGPs have got 15-30 appointments.

PROF KING: Yes.

MS CHELIUS: There's a lot of assessment to be done when somebody presents with a possible eating disorders. And history, it's metabolic rates, it's all of that stuff so we've created a lot of resources for GPs and NEDC is really good, that's from Butterfly Foundation, to help educate but I think they struggle and they scare because it's got the highest mortality rate of any mental health concern so it's hard, there's a huge burden on RGPs.

PROF KING: So one of the things that you said sort of worry me. You said - and I want to make sure I got it right - mainly your services are step down so it sounds like, you know, even if they are seeing GPs or whoever, for generally young people, end up in hospital and it's only then that they start getting the relevant - - -

MS CHELIUS: Yes, unfortunately.

PROF KING: - - - you know, the specific services that they need for the eating disorder whereas if the GPs and the other (indistinct) pathways were effective I would have thought you'd see step up so - - -

MS CHELIUS: Hope so, yes.

PROF KING: So you just don't see any step up at the moment?

MS CHELIUS: Not yet, not yet. I think we're getting there so obviously with an eating disorder if you're in a full blown eating disorder, minimum seven years recovery and that's very conservative and we know they drop significantly with early intervention in the first two years and that cuts the cost - you know, if you look at the economic cost of an eating disorder, even if we look at productivity so - - -

PROF KING: So you've mentioned schools. Is schools really the main way to get that early intervention?

MS CHELIUS: I reckon schools are really, really important because it takes away from the stigma and especially in young, young males and I'll marginalise communities so it will be LGBTI communities, our indigenous communities. Indigenous communities now list body issues as number two according to the last survey done by - a very common survey, I've forgotten the name. It's Mission, It's Mission Australia does the surveys. So it's our marginalised communities too that have got high rates of eating disorders that are underreported and I picked up in the report about psychological therapies. It's more economical per session in block funded services.

Okay, so I actually don't understand that driver because a block funded service gives you more than just the one on one session, the block funded services gives you the group therapy, the meal support, the social connection, the carer support, integration back into community so - I'm not a mathematician, I'm a social worker - - -

PROF KING: Before I pass over to Harvey, because there's a couple of things I want to follow-up. Your school program, I think you said it hadn't yet been evaluated, you're working with?

MS CHELIUS: Queensland University.

PROF KING: QUT?

MS CHELIUS: QUT, yes.

PROF KING: Yes, okay.

MS CHELIUS: But we're doing it already and we actually have done it previously and it was called the 'I Love Me' project and it's very much peer-based run in the school with school leaders and that actually won an award, it was really so well received that we ran out of funds, so.

PROF KING: So was that actually formally evaluated?

MS CHELIUS: Yes, yes.

PROF KING: Okay, and - - -

MS CHELIUS: There were significant clinical outcomes, statistically I think the numbers were a bit too small.

PROF KING: Okay, so if we Google, 'I Love Me evaluation' - - -

MS CHELIUS: Yes, I could send - - -

PROF KING: If you could it send through, yes, okay.

MS CHELIUS: Yes, I can send that through to you, yes.

PROF KING: Just on gateways in step up, we've discussed about GPs. headspace, do you have interaction with headspace? Does it work as a doorway or a gateway for young people with eating disorders?

MS CHELIUS: We work closely with headspace, they sent them to us.

PROF KING: Okay, yes.

MS CHELIUS: So in the Brisbane big metropolitan area they either go through - they've been at RBH because there's five beds, they tend to step down into QuEDS, that is the day program, they can only take eight people at a time and then it comes through to us but a lot of it they'll self-refer into our service which they can. There is CYMHS who do the FBT which is a family-based therapy, doesn't work for everyone, it just does not work for everyone.

So because we've got that very eclectic approach, it's trauma informed with your DBT, with your acceptance commitment, with your CBT and we tend to say, 'What works for you?' and we create a therapy that suits the client.

PROF KING: Yes, just to come back to headspace, so you said they refer to you. So would that be people who are going to headspace, they haven't been hospitalised? I'm just again trying to work out do they have any effective step ups at the moment going?

MS CHELIUS: The step up for us would probably be us, (Indistinct words) Queensland. Yes, headspace but minimal practitioners that feel comfortable. I think that Taringa one we feel a little bit more comfortable working with eating disorders. I think we're still sitting in a space where it's crisis. My child is now underweight and there's significant physical harm and then we'll go to the GP because I can see they're losing weight where we know an eating disorder is dangerous 'before' we see the weight loss.

PROF KING: Yes.

MS CHELIUS: So I think there's still very much that gap between 'let's catch it' before.

PROF KING: Okay, you mention Brisbane, outside, rural and regional areas.

MS CHELIUS: Goodness, no, there's like - it's scary. Like, it's a rocky hospital that really tries but there's - so they just don't have - I know QuEDS try and do train, they also do state wide training for eating disorders but it's minimal. I think they might have one psychiatrist who will have an interest and they work across mental health so in my view, in my experience, and my colleagues would agree, it's a specialist field. You need specialist training, GPs, psychiatrists, who know the physical symptoms before they become evidence so, yes, a step up approach is - yes, at the moment we've got very much a step care approach, yes.

MR WHITEFORD: Okay. One more question before we finish. So just going back to work in schools.

MS CHELIUS: Yes.

MR WHITEFORD: So one of the things we've heard is, (1) that's a very important place to intervene; secondly, that the school curriculum is overloaded and there's not enough space to do pretty much anything else.

MS CHELIUS: Correct.

MR WHITEFORD: And that there is the - what used to be 'Mind Matters' now 'Be You' from Beyond Blue; so how would - what you do in schools fit into that, is it separate to the - something like 'Be You' or has it tried to be integrated or does that - - -

MS CHELIUS: It could probably work, some are integrated, but we focus specifically around eating, body image, social and cultural influences, so it's not - again it's not a generalist approach, we go in and we target that particular message around a culture around food about how you judge and what you look like because not everyone who diet gets an eating disorder but most people with eating disorders have dieted so it's a diet culture and obviously a very strong trauma informed mental illness.

PROF KING: Okay. And just on your block funded bit. It's not block funded services 'in generally', it's block funded so if you have a clinician who is receiving their remuneration through a block fund, so if we know there's a whole other bunch of stuff, they - well, some of the numbers are well below - (indistinct words) thing clients are well below what you would - - -

MS CHELIUS: So you're not talking NGO block funding?

PROF KING: No, no, no, it's that particular - you know, in other words if you're a clinical, how do the incentives change your behaviour to be able to see clients versus spend your day filling out paperwork or whatever else is happening so, yes, and some things are better block funded so - - -

MS CHELIUS: So just on suicide prevention eating disorders got 30 times more likely people to die by suicide. In Brisbane they are busy doing safe spaces that's connected to the emergency departments, I think that really needs to be reviewed. You cannot have a safe space attached to an ED for people that are as vulnerable as people with eating disorders. It's just it needs to be embedded - a safe space for prevention of suicide needs to be embedded in the existing resources like an NGO where they feel safe and supported.

PROF KING: Hang on, I'm going to follow up on that.

MS CHELIUS: I'm a bit worried about that.

PROF KING: So let's take something like the Safe Haven Café, it - - -

MS CHELIUS: Yes.

PROF KING: And one of the ones in Melbourne, St Vincent's is it?

MS CHELIUS: It is St Vincent's, yes, and they've got a good model but I don't think they attach to the - are they attached to the emergency department?

PROF KING: They're certainly closely connected to the emergency but physically they're separate so you don't go through the emergency department door because they're physically separate but the idea there is that it's open out of hours, the key thing is the out of hours because my immediate reaction when you said, 'Well, it's got to be through the NGO', it's got

to be an out of hours service because we know that's when the demand comes in the ED so do you mind clarifying what you actually mean by that; do you mean it can't be physically attached as in you don't go through the ED doors and then move off to the right or?

MS CHELIUS: And I think because it's going to be - my feeling on what I know is going to be run through HHSs so are we running just a replica of an emergency department which does not work for a very vulnerable group of people and - - -

PROF KING: So does not work means it's not safe or it's not therapeutic?

MS CHELIUS: Both. It's not safe, there's a stigma around people with eating disorders and personality disorders that present; why don't you just eat? Like, 'Why are you here?' Now I've got suicidal ideation. Well, you know, you can wait because I understand that somebody with psychosis presents more scary and needs more attention and I get that, I'm not at all stigmatising them, we can't combine the two so I think we need to think this through that everything was attached to a HHS because are we, my question is, creating just another extension of an emergency department or are we saying there's existing resources, yes, it's got to run after hours but how does that work with a vulnerable group, it's usually young women with major trauma, either sexual assault, historical sexual assault with an eating disorder and the same for young males that are transgender or LGBTI. You're putting them in an environment that's not safe, have got - there's always somebody that's more unwell.

PROF KING: But that wouldn't let us off the hook, I think, for trying to say that emergency services should be more sensitive to dealing with people with eating disorders.

MS CHELIUS: Yes, 100 per cent, 100 per cent, but if we're looking at safe spaces let's not create another model because I know there's this movement about less NGOs so that we can all deal with one big generalist service, that's very much a message we're getting - - -

PROF KING: From?

MS CHELIUS: From hospital health services, they don't want to deal with a million little NGOs, it's inconvenient. But you know why it's convenient for the client because they could choose so if we had one big generalist that's a whole other talking point for me, generalist approach. It doesn't work for mental health issues especially not for something like sexual assault, domestic violence, eating disorders, that's pertained to a very vulnerable cohort.

PROF KING: So - - -

MS CHELIUS: Yes, okay, I'll just - - -

PROF KING: You've gone down another track.

MS CHELIUS: Sorry.

PROF KING: So consumer choice - - -

MS CHELIUS: Consumer choice.

PROF KING: Consumer choice is important. We understand how consumer engagement is important in their own care and choice is part of that engagement because it empowers the consumer. But how do we make or how do we enable that when our clinical systems are very much, you know, not meaning this in a bad way, but it is, you know, and escalator. You know, you get on at the bottom and you get out at the top type of thing.

MS CHELIUS: Yes.

PROF KING: And so how do we make that or enable that consumer choice around a clinical system and then, how would we do it outside the urban areas?

MS CHELIUS: I think again, I come back to, in Brisbane, we had PIR in the hospitals. So you have that one constant care to - - -

PROF KING: So it's to navigate, okay.

MS CHELIUS: Care coordinator who says, 'Eating Disorders, these are the options, would you' - you know?

PROF KING: Okay, yes.

MS CHELIUS: So again, it's that one consistent and that's what PIR did really do well because I don't know if it happened everywhere, but we embedded it in the hospitals.

PROF KING: Yes.

MS CHELIUS: I think it's harder in rural and remote communities because there aren't as many services to navigate people to. So it's again, coming back to funding

PROF KING: Yes, okay, all good?

PROF WHITEFORD: All good.

PROF KING: Thank you very much for that.

PROF WHITEFORD: Thank you.

PROF KING: And then we were just warming up but it always gets me worried. I stop talking when - - -

PROF WHITEFORD: No, okay.

PROF KING: All right, Carol, you can come down. And so, Carol, if you're able to state your name, group that you represent and any opening comments that you'd like to make.

MS MARKIE-DADDS: Thank you. Good afternoon, I'm Carol Markie-Dadds. Can you hear me okay?

PROF KING: Yes, all good.

MS MARKIE-DADDS: I'm Carol Markie-Dadds and I'm the Country Director for Triple P International in Australia. Before we begin, I'd like to acknowledge and pay tribute to the Darambul people, the traditional owners of the land we are gathered on today, and pay my respects to the Elders past, present and emerging.

Thank you for the opportunity to speak today and for the extensive work and consultation that has gone into the draft report. For my opening remarks I'll highlight the critical role of a safe and stable parenting environment as a protective factor and determinant of a child's mental health and resilience over their life span. I'll also comment on a few general areas from the draft report pertaining to prevention and early intervention for mental ill health and workforce professional development before taking any specific questions you may have, particularly around implementation examples, system design, cost-effectiveness and outcomes of the program.

PROF KING: Thank you.

MS MARKIE-DADDS: The Triple P, Positive Parenting Program, is a University of Queensland developed system of parenting support interventions and, more recently, includes professional development for educators. It's one of the most effective evidence-based parenting programs in the world. Of all the factors of effecting a child's life, parenting has a critical and pervasive influence over the life course and Triple P's expertise is in promoting the mental health and resilience of children by increasing the confidence and competence of parents.

Triple P has proven effectiveness across a number of outcomes, including improving children's mental health and wellbeing, reducing the numbers of children in out-of-home care, improving educational results, improving children's relationship within and outside the family, supporting Indigenous families and reducing behaviours in young children shown to place them at a risk of lifetime offending. Additionally, we know that low intensity programs, as well as online programs, are effective in addressing childhood mental health problems and these delivery modalities are engaging vulnerable families.

Although I'm here, today, with my Triple P hat on, I speak to the general endorsement of rigorously evidence-based and cost-effective parenting supports as crucial to the transformation of Australia's mental wellbeing into the future.

I cannot stress enough the necessity of supporting parents, and by extension, their children, if we truly desire generational change and reduction in mental ill health and the other life challenges that mental ill health presents. The social determinants lands of the Commission's draft report is very welcome and the specific recommendations around social and emotional development and learning in early childhood in education settings, shows recognition of this critical time in a child's life.

In particular, Triple P International strongly endorses the recommendation to expand the purview of early childhood health checks, to include social and emotional development

before pre-school, the expansion of parent education programs and increased attention and quality control of professional development for early childhood educators.

We note the extensive literature around the implications of the first 1000 days of a child's life for broad outcomes across the lifespan. NSW Health has recently released a first 2000 days framework, which takes this concept further to comprehensively deal with the importance of school readiness and quality early childhood education for long-term outcomes.

Any reform work that targets the mental health and wellbeing of children must include consideration of the environments that children live in, which is one heavily influenced by interactions and relationships with their parents and educators. On this theme, p.650 of the draft report notably reads: 'The effects of reforms and other interventions will be short lived if those working with children and young people are not equipped with skill sets that enable them to continue to support better mental health and wellbeing in their ongoing work. Supporting children's mental health means also supporting those crucial people around them to avoid exacerbating any stressors and enable positive social, emotional and behavioural development.'

Educators as well, must have quality professional development that includes all competencies around confidence in consulting with parents of children in their care in regards to social, emotional and behavioural issues in development. There are obviously some challenges to the regulation and funding of professional development in the early childhood sector given the public private mix. But it's crucial this sector is acknowledged for the importance it can have over long-term outcomes for children's mental health and wellbeing.

In acknowledgement of this crucial role of earlier childhood educators, Triple P has begun to make available it's evidence-based professional development program Positive Early Childhood Education, with the knowledge that for every \$1 spent on quality early childhood education, an estimated 1 to 5 dollars is returned to the economy.

An RCT of this program resulted in significantly less disruptive child behaviour and self-reports from educators found they felt less stressed at work, communicated better with each other and supported each other, they felt more prepared and supported to meet complex needs and respond to child behaviour that they found challenging.

Importantly, educators said after the program completion, that they had a better understanding of their own personal capacity to bring about change in children's' behaviour and the value of collaborating with parents to support children.

We know that building resilience is a crucial protective factor against mental illness. Some key findings just released from the longitudinal survey of Australian children which has followed 10,000 children since 2003, found that resilience levels were higher among 16 and 17 year olds who had consistently close relationships with one or both parents and average resilience levels were lower for those 16 and 17 year olds who experienced conflict with their parents between the ages of 12 and 15 or who lacked family support between the ages of 10 and 13.

This goes to the need to support parents as crucial to children's mental health and wellbeing even as they get older and move into secondary education. Additionally, as with early childhood, workforces interacting with older children, educators, psychologists and the proposed wellbeing leaders, must have the capacity to hold meaningful and constructive consultation with parents and not treat children in isolation from their environment and immediate home and family contexts.

The cost-effectiveness of prevention and early intervention of parenting and early childhood support acknowledged in the draft report, can only be realised where implementation is carried out effectively, and we support the greater monitoring of outcomes suggested in the recommendations and more stringent requirements on evidence-based and prove cost-effectiveness of programs prior to their funding.

The Australian Early Development Census is a great data tool to assist population level to this end and could be utilised more comprehensively by funders. On the note of cost-effectiveness, independent modelling has shown that early investment in the Triple P system by governments generates a benefit between four and 12 times the original spend.

The recommendation around a national mental health workforce strategy is also very welcome, but I would suggest that the proposed parameters are too narrow in their focus on the clinical end of the workforce spectrum and that to truly achieve the whole of government reform of the mental health system, the workforce strategy must incorporate consistent professional development requirements and adequate funding to enable those for workforces that are not exclusively in health but in the social determinants portfolios as well.

The workforce with primary perview over infants, children and young people again, must include key competencies around engaging constructively with parents about their child's development.

We will be making a more substantial written submission further addressing the draft report. But for brevity sake, I thought I'd give more time to questions so that you can target further information that may be useful to you. In addition to the areas covered so far, I can speak to the examples of recent population roll outs of parenting support in Australia, including in Queensland, where the state government has made Triple P available freely to families for the last four years, reaching an estimated more than 335,000 parents and carers, as well as in Western Australia, where the government is offering parents free access to positive parenting seminars in their local school or child and family centre as part as the kindergarten enrolment process, and more recently, to reach parents and children making the transition to secondary school.

I have examples of implementation and outcomes of parenting support used across four of the major objectives areas identified in the draft report, including early childhood, school settings, workplaces and the justice system, and I'm also happy to discuss with you how parenting support that is delivered in partnership with existing social services and community infrastructures systems is most effective and, indeed, most cost-effective. Thank you.

PROF KING: Thank you. Now, you referred to a number of cost-effectiveness studies and evaluations, particularly of Triple P.

MS MARKIE-DADDS: Yes.

PROF KING: If at some stage, and it may be in the submission, just so that we have the links so that I make sure that the relevant people on the team can find those, that'd be fantastic.

MS MARKIE-DADDS: Sure.

PROF KING: A number of questions; but let me start off at the end. Parenting support; so one of the things that I do get concerned about with parenting support type programs such as Triple P - you mentioned the one in WA - is that there's a self-selection. So it's been put to us the problem is that it's the parents who actually aren't so much in need of the support are the ones who are much more likely to say, 'Yes, we'll do the program,' and the families and the parents that really need the support and the information are much less likely to do the programs because they're the families that are already under stress, whether it's financial stress, whether it's other issues in the family and so on.

So it's been put to us that, you know, you might get these great evaluations where they're done on selected groups of families, but when you actually roll the programs out, at least it's been put to us, they don't work because the wrong families engage.

MS MARKIE-DADDS: Okay, so I would challenge that we're not able to reach vulnerable families. So let me just give you some data from Queensland where we've been doing the roll out. So essentially here, I guess essential tenant of Triple P is that we're using a universal delivery system. So we're making it normalising, destigmatising to attract all families to come along and access parenting support.

So similar in WA and in Queensland, it's offered universally and it's great if you can pair it with, like, starting kindergarten. It's as normal as enrolling a child in kindergarten that parents also attend a positive parenting seminar or as you're child makes a transition to high school. That's another good check in time for parents to access parenting support.

Also, making programs available in a multitude of formats. So rather than one on one face-to-face traditional therapies, we've got programs available in large group seminars. So families that want to just come along and listen and don't want to put their hand up and speak, they can feel comfortable in that large group environment.

There's also multi-week smaller group programs if families prefer that. There's self-help options with workbooks and online programs. There's telephone assistance options so we can reach families that are rural and remote or work; child care issues, unable to access face-to-face services. So making the programs available in a whole range of different delivery formats means that there's something for everybody and they can choose the format that matches their particular requirements.

So just to give you some indication of the reaching Queensland, it's been going for just over four years now. We've estimated we've reached 336,000 parents and carers. Of those,

54,000 are opting to do the program online. So we have a version for parents of younger children under 12 and a version of Triple P for parents of teenagers.

So working through the program, it's supported via a communications campaign to raise awareness and to let parents know where to access some support. We've got a comprehensive website specifically for Queensland parents with information on as well, and where they can find sessions and enrol in events or find a provider.

In terms of the state-wide representation in Queensland, at the moment, our data is looking at how many health care card holders we're attracting and that's our proxy indicator of a low income family.

PROF KING: Yes.

MS MARKIE-DADDS: The estimate is about 20 per cent of Queenslanders would have a health care card. Our current number of parents completing Triple P is 29.6 per cent; so they have a health care card. Aboriginal and Torres Strait Islander families: This is an underestimate because it's only those who are accessing services through a web-based portal. So they're registering for a seminar, an online program.

PROF KING: Yes.

MS MARKIE-DADDS: We've estimated about 3.8 per cent of Aboriginal and Torres Strait Islander adults in Queensland. 4.3 per cent are identifying as Aboriginal Torres Strait Islander on our online registrations.

In addition, we've trained over 125 practitioners who work specifically with Indigenous families across Australia and particularly up in the north. Speak a language other than English: The community prevalence in Queensland is about 7 per cent. 14.5 per cent of our families report they speak a language other than English at home, and 16.1 per cent of families in Queensland are single parents and we've attracted about 24 per cent are reporting that they're single parents accessing services.

So in terms of those core indicators of vulnerability that governments often use, we're certainly reaching those cohorts and it's similar numbers in terms of enrolments in our online programs. So the reach. It's not so surprising I guess if you're low income, you're a single parent, you can't access child care, transport or you're looking for out of hours.

PROF KING: Yes.

MS MARKIE-DADDS: So we do find that a lot of our online users are using the program between 9 pm and midnight to work through the program. There's a number of randomised control trials on the impact of the online program showing that it is as effective as our equivalent face-to-face, 1 hour a week for 10 week program and it's shown to be effective with children - well, families presenting with children with quite significant behavioural and emotional problems, including ADHD symptoms, early onset conduct problems.

PROF KING: Costs?

MS MARKIE-DADDS: The cost of the online program?

PROF KING: Well, do both for me. So costs to the parents who attended the 10 week program and the cost of the online program.

MS MARKIE-DADDS: Well, in Queensland the Queensland government is providing the access to the online program. So in Queensland the cost repair ant is nil.

PROF KING: For the online program?

MS MARKIE-DADDS: Yes.

PROF KING: M'hmm.

MS MARKIE-DADDS: A parent interstate accessing the program, 7995 for the program.

PROF WHITEFORD: Online program? And what about the face-to-face or the group - the one tentative (indistinct).

MS MARKIE-DADDS: Well, it'll vary if they're - like, in Queensland NGOs and health departments are providing it free of charge to their service deliver. If you got to a private psychologist those are the rates. So the rates vary, probably \$100 plus an hour to access those programs.

So where a private psychologist delivers it, they would've been trained - to have some credentials to say, 'I can deliver the Triple P program that's got vedelity with - what's (indistinct) show in the clinical trials in (indistinct) process.

That's right. So our organisation, Triple P International, is essentially a professional development organisation so we have the licence from the University of Queensland to disseminate the program world-wide and so we run I guess dissemination implementation. So in Queensland, we've been with any NGOs and government agencies who are wiling to provide Triple P, free of charge to the end user.

So these are services that are typically funded federally or by the state government to provide parenting and family support from light touch or to intensive interventions.

PROF WHITEFORD: And apart from Western Australia and Queensland, other states that you're in?

MS MARKIE-DADDS: We're in most states but to varying degrees.

PROF WHITEFORD: Internationally?

MS MARKIE-DADDS: Twenty-eight countries that we're offering - that are running Triple P. We've got offices in about eight different countries and was translated in around 20 languages.

PROF KING: The program itself, how does it - well, does the program differ, is it modified at all depending on the background of the parents, perhaps their ethnicity or any other factors that may mean that their vulnerabilities, their ability to engage effectively with the parenting program changes? So how much flexibility is there?

MS MARKIE-DADDS: Yes. So there is quite a bit of flexibility within the program. We always talk about it as flexibility and fidelity. So the core principles of Triple P remain consistent, the core strategies within the program remain consistent, but the way in which they're presented and shared with families will vary depending on their particular circumstances. So if you're familiar with Triple P, there are a whole range of resource tools that can be used to supplement the information that's provided, videos, tip sheets, workbooks and so on.

But if we're working with an illiterate family, then those tools aren't useful for that particular family, they are of more benefit to the practitioner and making sure that the practitioners are sharing accurate information with the family. But the way they share that information will be tailored, depending on the presenting family. So whether you're sitting under a tree out in regional Queensland or you're in a more structured formal environment in an office clinic.

PROF WHITEFORD: So one of the recommendations in the draft report, and you've referred to it, is the idea of a three year old social and emotional wellbeing check. Now, one of the concerns that's been raised there, there's been a few, one's around stigma of trying to diagnose a mental health problem in a three year old, which I guess we're not trying to do. What we're trying to do I guess is identify children at risk or where some sort of help is needed for the family. So the second issue therefore is once you do the checks, what do you do if you find a family that needs assistance and because by doing the checks you're likely to throw up considerable unmet need. What's the capacity of a group like Triple P to respond to that if that's, you know, one of the solutions?

MS MARKIE-DADDS: Yes. Well, we would think it's about embedding the support in the workforce that has the most contact with those children of that age group. So in particular, the early child education and care sector, so particularly now over 90 per cent of four year olds are accessing kinder or preschool in the various states and territories. So it's about embedding the support or the skills within that workforce to support those children and parents.

So it's that early intervention as well. If we're getting in early, it's light touch interventions, so things as simple as seminars at kindergartens and preschools and it's upskilling the existing staff within those services. So in WA, kindergarten's offered through their state schooling system, so it varies in from jurisdiction to jurisdiction as to who offers that part time year of schooling. But in those jurisdictions where it is in the school environment, they have the luxury of being able to use the school based staff, so they have school psychologists who are able to then run those seminar events.

New South Wales is in the process of increasing their workforce of psychologists and counsellors, particularly in the high school setting. And again, they're the sorts of professions where they could be running transition to high school seminars on positive parenting and

even picking up on some of the topics of the last speaker, a whole host of seminars could be run through the year, targeting the parents of those age groups.

So we would say I guess that key point I wanted to make was when we have just started doing the positive early childhood education program, which has been developed specifically for educators and it's really come out of that demand because educators were asking us, well what can we do in our environment? Because we're supporting parents on the one hand with Triple P and what can we be doing in the centre?

The thing that I found most powerful was that it wasn't until they did the program that they realised that they had their own capacity to actually make a difference in that child's life and they were always looking for where can we refer this child to rather than what can we be doing in the day to improve their resilience and self-regulation skills.

And that's really I guess what we'd be looking at identifying in that three year old health check, those children that are having difficulty regulating their emotions and coping with changes, who are easily distressed or upset. And then if we can provide some tips and ideas to the staff within those early childhood education and care settings, we can make a significant impact then so that they make a smooth transition to that first year of formal schooling.

So I think if we looked at that AECD data, the Australian Early Development Census Data, New South Wales, I think it was last year, they looked at all of the children starting their first year of formal school and they could identify those children who scored as vulnerable on measures of social competence and social emotional adjustment and those are the children that perform poorly through the literacy and numeracy tests and so on.

But if we can get those support and help those parents with those children at three, and it is usually around routines, like a good sleep routine, a good eating routine, a good getting out of the door in the morning routine, then those make a significant change to that child's life.

PROF KING: Other doorways to the service, so workplaces or other - - -

MS MARKIE-DADDS: Workplaces are ideal if we can I guess put the systems in place that allow the staff who wish to come to the events, the freedom and the ability to come. So when we first started the Triple P rollout in Queensland, we did have an employee assistance program strand, I guess, and we offered seminars in government facilities for about 200 odd workers came along. They all found seminars successful or effective and beneficial for them, but it was more about pragmatic issues about whether they were able to come along or at the last minute work was too - issues arose that made it impossible for them to attend and so on.

But having the seminars supported by the online program, so there was always that backup option that if families, if they couldn't come during work time, they could come after hours via the online program.

There's been a bit of research that we've done, particularly with teachers, with - I'll just find some notes, with workplaces who have been offered Triple P as a workplace program, where

we offered it to them through the education department in Queensland a few years back, I can send you the research paper for this particular one, offering it to teachers who were parents.

So we spoke to them as though they were parents, well they were parents, they went through the program as a parent would experience the program. But they were able to generalise the strategies and information that was presented for them as parents to their classrooms and reported lower levels of classroom stress and increased confidence in their ability to respond to children's behaviour and most significantly they reported that they were much more less likely to consider resigning in the next five years.

So when - and that's part of the rationale and why we're starting to move into providing an adaptation of the program specifically for those in education centres and starting with that early childhood.

PROF KING: That would be the further development - part of their further development?

MS MARKIE-DADDS: Yes, yes. So at the moment we can - - -

PROF KING: Professional development - - -

MS MARKIE-DADDS: Yes, we're supporting teachers more to provide advice specifically to parents though.

PROF KING: Yes.

MS MARKIE-DADDS: Yes.

PROF KING: All right. Thank you very much.

MS MARKIE-DADDS: Thank you. Was there any other particular research references or areas of research that you were interested in? I've got the cost effectiveness, broad research outcomes - - -

PROF KING: The evaluations. I'll let Bill grab you if there's other things that we need.

MS MARKIE-DADDS: Plenty of evaluations of real life rollouts, yes.

PROF KING: That'd be fantastic.

MS MARKIE-DADDS: Thank you.

PROF WHITEFORD: Thanks very much.

PROF KING: All right. We're going to have a break for lunch until 1.30. We've got a couple of people by phone after lunch. Anyone else? Bill?

UNIDENTIFIED SPEAKER: No, I'm just with Carol.

PROF KING: No, sorry, I'm looking past you to Bill. Bill's sitting over right behind you. Sorry. I noticed before when I mentioned Bill and you saw my head looking there. So just lunch now and there's two by phone afterwards. All right. Back at 1.30, guys.

LUNCHEON ADJOURNMENT

RESUMED

(Telephone link established.)

MR WELLMAN: Hello.

PROF KING: Hi, is that Robert?

MR WELLMAN: Speaking. Speaking.

PROF KING: Yes, Stephen King from Productivity Commission here.

MR WELLMAN: Hello, Dr King, yes it's Robert Wellman. We met at the meeting with the Mental Health Coordinating Council. You might remember.

PROF KING: Yes. Yes.

MR WELLMAN: And we had a brief conversation but you were in a hurry to get your flight.

PROF KING: Yes. That sounds pretty much like me, yes.

MR WELLMAN: Well look you're all to be congratulated, it's a huge task and I've been listening to my colleague from Mental Health Carers New South Wales, Andrew Pryor was on the public hearings and I've been hearing a lot of it.

PROF KING: Yes.

MR WELLMAN: As you know I'm a (indistinct) - - -

PROF KING: Hang on. Before we get started, because we are on transcript, so do you mind just formally stating your name, your position and then, yes, any intro remarks you'd like to make.

MR WELLMAN: Yes, sorry. Yes. It's Robert (Indistinct) Wellman. I'm an aged pensioner and I'll be 75 next birthday. I've been a mental health carer for 20 years and I've done voluntary work in the mental health sector and I'm currently on the board of Mental Health Carers New South Wales.

PROF KING: (Indistinct).

MR WELLMAN: I've got a - I'm a retired TAFE teacher and I've got a basic science degree. So I understand a bit of science but of course at times I'm out of my depth. So that's where I sit, yes.

PROF KING: All right, and - - -

MR WELLMAN: (Indistinct).

PROF KING: Yes, so what would you like to tell us?

MR WELLMAN: Well, I suppose my goal in life was to have my son in a better position before I drop off the perch. So I've listened to a lot of the hearings and a lot of feedback and there's huge contribution. What the - there's been a lot about early intervention and schools and everything like being involved. I just wanted to change it a bit away from the pharmacology where local mental health service tick the box and it becomes an Olanzapine or a Clozapine culture sort of thing, and move away from that to technology that's being done overseas in relation to treating mental health because I'm sure if we were to pour more funds into the research there'd be a cost saving, which is what you guys are looking at.

There was a study done at the Philadelphia University in the States. It was a huge sample, 700,000, and what it showed was that those people that showed symptoms, not necessarily a diagnosis of OCD, obsessive compulsive disorder, but those people went on to develop more serious mental illness. So if we can stop that trajectory that'd be wonderful. One of the things they do in Finland (indistinct words) is open dialogue, which no doubt you've heard about where they bring in the school counsellor, all the parents, the siblings and everything and work through the issues early in the piece and as a result of that their mental hospitals are empty and they get employability results nearly equivalent to the mainstream population.

Now the bit I want to talk about is other treatment things that are being done. One in particular is targeted TMS. This is where they put the photo of the brain up and they stimulate the frontal lobe and hopefully pick up the connections into the (indistinct words) where a lot of these (indistinct) communications take place. Those two researches are being done - and there's two lots, one up in Queensland with Dr Luca Cocchi and Professor Breakspear and the other - and they link with each other - is at the Epworth centre with Professor Paul Fitzgerald, and as we speak a family member is doing that TMS clinical trial down there with Professor Fitzgerald. So that's looking promising. (Indistinct words) - - -

PROF KING: Sorry, just to clarify, so TMS?

MR WELLMAN: Trans (indistinct) - no, sorry, trans magnetic stimulation.

PROF KING: Thank you.

MR WELLMAN: Targeted trans magnetic stimulation. The other one which has got FDA approval in the States is dTMS. So that's deep brain TMS and it's got FDA approval and I we

do have two machines here. One Professor Paul Fitzgerald's got, and one I think it's at Black Dog. Now they haven't been used because of some hitch about - it's so expensive they've got to put a card in or something and that clocks up (indistinct) dollars going to BrainsWay in the States. So it's a BrainsWay machine that fits over the head like a hairdryer, and they've had a 38 per cent efficacy in the States. Now that's another worthwhile thing which is - both those things are unintrusive compared to DBT and would be really worthwhile to pour funds into that research because even if there's only a 30 per cent efficacy it would reduce the numbers in acute care.

So I'm just looking at, you know, perhaps changing the waking a bit away from every conference I go to either have got another neuroelectric that doesn't have the same metabolic syndrome etc. etc. well we need to move away from that to these newer technologies and that's sort of - I haven't had - I hoped to get the research papers to you on all of this I'm talking about, I haven't had a chance yet. And the last one I want to mention is focused ultrasound, and no doubt you've probably have saw the paper about the guy with the tremor and they did the focused ultrasound and it stopped the tremors. Well, they're now using that, that's a bit more intrusive because they use the sound waves and they can link it up really accurate on the part of the brain and it's much less intrusive than DBT.

And there's a lot of research going on there in Canada, Toronto, in relation to focused ultrasound, and we're talking about depression and OCD here for these treatments. So that's basically what I'm on about to spend more funds and look at other ways instead of neuroelectrics antipsychotics, you know. Curtin University did a huge research paper on neuroelectrics, and basically I spoke to the lady, a professor there, and she gave me the paper. Basically what she came up with - she did an enormous, a hundred and something references of research she'd looked into and since the introduction of these first generation neuroelectrics the incidents of mental illness there's a trajectory upwards, an exponential increase in America, UK and Australia and these countries since their introduction.

Now in other countries like Africa and Asia countries there's - the incidents of mental illness stayed the same. So she's arguing that there's a case building not to use them at all or only in very rare cases and of course you've seen the present patients in the public sector, people coming in, the side effects, metabolic syndrome and the shocking toxic effects that these - especially Clozaphine, Olanzapine cause to these poor people. So that's her argument. It's another bit of research that people probably haven't heard about. And (indistinct) - - -

PROF KING: Sorry, that was a researcher at Curtin University, did you say?

MR WELLMAN: Yes, it was. It was Professor Kate - it's a Russian name and it begins with - starts with K - Koskoski or something like that.

PROF KING: That's all right. We can try and find it, that's easy, yes.

MR WELLMAN: Yes. Yes, so that was - but it was a huge - it went for a number of years. She did a lot of research in relation to neuroelectrics and that was the conclusion they came up with. And the final thing I wanted to say, Dr King, is that the coroner is often - you know, his recommendations, some of the - if you read - they're open to the public, some of his reports in relation to inquests and he's highly critical of the management of these people and

what should be done. But government seem to not take any notice even though the 2009 coroner act is a very powerful piece of legislation and the coroner is in a very - some of his findings have been very insightful and as far as I'm aware there's very little data in relation to analysing the coroner's inquest reports to try and pick up some kind of pattern or some kind of trend.

And I don't think any university or government authority has done that. When I've raised it with Suicide Prevention they said "Rob, there's no political appetite." Well, you know, we're looking at a huge trajectory, you know, this is really vital to the country and as KPMG - the report there said, you know, we're losing a generational productivity and costing the nation a fortune. We're pouring buckets of money into it but there's still a trajectory. So I would have thought, just from my basic science and enquiry for an old retired pensioner that there should be more research in relation to the inquests and those hearings and the decisions that they hand down, because it may well be there's a trend.

I've noticed where there's a lack of communication in relation to medication when they're released from acute care, and things like that. I've only sort of touched the surface of it, but yes that's all I wanted to say coming from a research and science perspective.

PROF KING: Yes.

MR WELLMAN: To really have a look at that because that's where in the long term I feel the solution lies, not to be stuck in the medical model and, you know, the same old story, you know, the guy writes out the script, "How you're feeling?", gives you another script and nothing much happens and no novel techniques are seldom tried.

PROF KING: Yes.

MR WELLMAN: He did five weeks trial up in Queensland. He did one the middle of this year at Epworth, Monash University, and at the moment he's doing a third one after the washout period in the other one, and in fact I spoke to him on the phone yesterday and he was quite lucid and I'm hoping this time he's not the placebo and got the active treatment, because half of them are placebos so you - - -

PROF KING: Yes.

MR WELLMAN: - - - spend all this time and effort and you might not get a hit. But anyway the research is really - in these new technology - worth pursuing. I really mean that, Dr King, I'm very - and if there's anything I can do to assist or follow up with research papers, I've got quite a number of them, I'd be prepared to do that.

PROF KING: Okay. Thank you for that. When you say they're - I mean they're new technologies but they're still medical technology. So when you say - you sort of - you mean - when you say non-medical do you really mean non-medicine based as in non-pharmacological?

MR WELLMAN: (Indistinct words) pharmacological.

PROF KING: Yes. Okay. Okay, yes.

MR WELLMAN: So they're probably - yes, I'm probably wrong there. They're probably still medical, yes, non-pharmacological, you know, of the - I know from my volunteer work some of the poor sods are on a plethora of medication.

PROF KING: Yes.

MR WELLMAN: And yes it's - I can't - after that research done at Curtin University I really can't think that's the answer in the long term at all.

PROF KING: Yes, and just to clarify the research at Curtin that was just looking at the neuroelectrics class of medicines.

MR WELLMAN: Yes, so research in relation to neuroelectrics. That's right.

PROF KING: Okay. Yes. Yes.

MR WELLMAN: The antipsychotics, yes.

PROF KING: Okay.

MR WELLMAN: All the side effects and trends and she did a massive literature survey and summarised it all. I think it was done in conjunction with Mental Health Carers Australia or one of those people, I'm pretty sure.

PROF KING: Yes.

MR WELLMAN: And she got funding for that, but it was very good and she had every day cases of people suffering on the neuroelectrics and what happened, and it's backed up by the research and then of course you've got the other three things, the targeted TMS - this is different to just straight TMS, so it's targeted - dTMS and focused ultrasound are the other three I mentioned that - - -

PROF KING: Yes.

MR WELLMAN: You know, they're very much - see in the States they've got a hundred sites for the dTMS, the BrainsWay machine. A hundred sites. We haven't even got one up here. Not one.

PROF KING: Yes.

MR WELLMAN: So, you know, we seem to be - like in some areas of medicine we're leaders - - -

PROF KING: Yes.

MR WELLMAN: - - - but in mental health we seem to be really dragging the chain compared to what's happening in other parts of the world, the western world (indistinct).

PROF KING: Okay. I mean with these particular interventions though, whether it's focused ultrasound I understand is really - has been shown successful on certain neurological conditions so sort of tremors, Parkinson, those sort of conditions, I - - -

MR WELLMAN: Yes. They're doing a trial for OCD in Toronto at the moment, yes.

PROF KING: Okay. Yes. TMS - and again apologies I don't know the details on targeted versus deep brain and so on, but mainly for depression I thought that had been shown - - -

MR WELLMAN: Yes, it's mainly for depression but they've also got FDA approval for dTMS for OCD.

PROF KING: Okay.

MR WELLMAN: OCD, there's three subsets of OCD. You've got the symmetry, you know, they want the pencils all lined up. You've got the contamination, the hand washer. Then you've got the intrusive thoughts which is the subset - - -

PROF KING: Okay.

MR WELLMAN: - - - the most difficult one to treat. In other words they have got refractory OCD. It doesn't respond to cognitive behaviour therapy or exposure response therapy.

PROF KING: Yes.

MR WELLMAN: So that's where - and it's interesting that that subset, the intrusive thought subset of OCD, according to the Philadelphia study is the one most likely - if you pick it up early when they're kids, are the most likely subgroup or subset to develop more serious mental illnesses.

PROF KING: Okay.

MR WELLMAN: And that's why I'm very interested in OCD because OCD if they've got that as a child they're more likely to develop a mental illness in their teens and sort of that 15 to 25 age bracket.

PROF KING: Okay.

MR WELLMAN: And so - yes, so there is a lot of work being done with targeted TMS and dTMS now for OCD and equally of course as you correctly say for depression.

PROF KING: Okay. All right. Okay. Well, thank you, Robert, that's been really very useful. If you've got any links to stuff - I suspect the teams got access to the published

studies but if there's anything that you've got that you think isn't generally available or maybe a bit obscure and we may not have - - -

MR WELLMAN: Yes.

PROF KING: - - - please just send through the links to Bill and that'd be fantastic.

MR WELLMAN: So if I send them to Bill - - -

PROF KING: Yes.

MR WELLMAN: - - - hopefully that'll be a contribution.

PROF KING: Yes, that'd be brilliant. So thank you for that.

MR WELLMAN: Yes. I appreciate your time and it's got to be the hardest topic ever. You're doing - really giving everyone a fair go because there's so many groups out there that are doing good work and that, but how you coordinate it all together it's just such a huge task, and also politically, Dr King, the politicians that we've had - any maybe don't quote me on this one - the politicians we've had over the years, none of them have a science background and the science lacking in the departments, so there doesn't seem to be the lobby for more work done in research in new technologies for treating mental illness.

PROF KING: Yes, I don't think there's too many scientists in parliament in general but - I think they're all lawyers, aren't they?

MR WELLMAN: Something like that or professional politicians.

PROF KING: Yes.

MR WELLMAN: But in saying that, to have someone - like Geoff Gallop suffered from a mental illness (indistinct words) - - -

PROF KING: Yes, there's people with lived experience there, you're quite correct.

MR WELLMAN: Because these people, when I visited the labs and saw what was going on, I've got a basic science degree, the algorithms and the work they're doing is just truly amazing. And they're really smart guys. They're the ones that need to have the support to try and come up with these new techniques and that to try and relieve the suffering of these poor people. You know, it's - I don't know whether you've visited mental hospitals or acute care.

PROF KING: Yes.

MR WELLMAN: But no, it's - - -

PROF KING: Been on the wards, so yes.

MR WELLMAN: Yes, it's terrible.

PROF KING: All right, Robert.

MR WELLMAN: All right, thanks.

PROF KING: Thank you very much.

MR WELLMAN: Thanks so much for being congratulated on your work.

PROF KING: Thank you.

MR WELLMAN: So good luck so far. Okay.

PROF KING: Thanks, bye.

MR WELLMAN: Bye-bye.

(Off record discussion.)

PROF KING: What would you like to tell us?

ANONYMOUS: Thank you. Okay, well I'm a person that has tonnes of experience in what I'm about to tell you, but I'm also speaking mainly as an advocate. I am a retired health professional, but I did work in this area. And I've (indistinct) been given the opportunity to talk with you today. I've read much of the draft report and many of the submissions, however, I did not find reference to the issue that I'll raise for consideration today.

I became aware of this issue first about 18 months ago, and growingly over the last 18 months as I tried to assist a young man in this situation, trying to find knowledgeable family law and mental health assistance, as well as organise other support.

During this time, I also experienced a horrific grief and emotional pain suffered by those involved and found myself feeling quite helpless, unusual for me, and quite anxious as I tried to assist and find a timely solution to this problem, which I realised would otherwise only get worse over time. So the problem that I'm referring to is the phenomenon that often occurs in high concept, acrimonious divorce or separation, where one parent intentionally, often very covertly, emotionally and psychologically manipulates a child to turn against and reject the other parent for no logical reason, and when there was a previous loving relationship, often because the child has internalised (indistinct) of that parent. Children need to love and be loved by those parents and extended family, unless there is a valid reason why it's not in the child's best interests.

So this phenomenon has been described since the 1980s, and likely before, and called various parental alienation, programmed and brainwashed children, pathological alignment, attachment-based parental alignment – alienation, I mean. Attachment related (indistinct) divorce, contact refusal, contact failure. And I quite like the term "contact failure", because

it's a bit less – less (indistinct) than the others. So like, parental alienation seems to be the common (indistinct) term at the moment.

There's been some controversy that surrounded the term, and some people are avoiding the term "parental alienation". So although there's disagreement about names and its exact description, but there's certainly agreement that the phenomenon (indistinct) damages of child and parent as well as extended family who are often also alienated.

One model described the phenomenon in terms of attachment theory, conflict, trauma, family systems, personality disorder and neurodevelopment of a child in a parent-child relationship, and calls for consideration of a special population group of family requiring assessment and treatment by professionals with specialist knowledge, training and experience and supervision. Because of (indistinct) studying from social psychology (indistinct).

Much to do with it is counterintuitive, as has been pointed out by a number of people. It's also been described as a form of family violence, because (indistinct) for other, using the child as a weapon, and then also described by the (indistinct) as a form of psychological child abuse and can be considered elder abuse because of the alienation of the grandparents.

The American Psychological Association states that psychological abuse is just as damaging as sexual or physical abuse, because it's harder to show. The research – quite a bit of research has been done by this and it does show that the alienated parent, or the person stopping the contact has significant psychopathology, often personality disorders, especially with cluster B, delusional disorders or Munchausen. There's lots of detachment between the parents and child – the parents without the contact, (indistinct) pathological enmeshment, children are traumatised by this and it's (indistinct words). Children want the alienation to stop, and – (indistinct words) one needs to look at the context in which that occurs, and the influence that it's been on the child.

So stopping this is imperative for promotion of the best interests of the child. This is not gender specific, but more commonly carried out by the (indistinct) parents, whether that's male or female. Alienation has been likened to cults and brainwashing. It's a global problem, and there are efforts in many countries to address the issue, and there is an international study group.

There has been a prevalent – recent prevalent study showing that in – I think in Rosen, Canada, Canadian town where they did – they came out with – I think 22 million parents of the 6.7 per cent children moderately, severely alienated, of the parents that felt that they'd been alienated, and so that came out at one point through the (indistinct) population, of the number of children. So there's severe long-term and short-term consequences for the child and for the other parent as well, such as poor self-esteem, depression, adult attachment styles, alcohol misuse, poorer self-direction and cooperation in the child. There's also depression, trauma symptoms and suicide within the alienated parent.

Often it's thought that they've often been poisoned by prior and continuing domestic violence of the emotional (indistinct) type, and coercive control to sabotage the child's relationship with the other parent. So currently, we're just trying to - I'm sorry, it's a bit - - -

PROF KING: No, no. This is fine. Yes.

ANONYMOUS: So there's some gaps in service availability and no clear - there are gaps in service availability and no clear pathways. So it's a family, mental health and child protection issue. However, it's not addressed as such, as it's usually dealt with in the courts as a child custody issue, where most, if not all, have inadequate training skill, knowledge, or experience to identify and assess, diagnose and develop treatment for - and referral to treatment. There's also a lack in (indistinct) practitioners of this phenomenon, and also, there are very few services in Australia, especially at the severe end of the spectrum.

So once it's in the court, it's too late, as the damage is already done. The more entrenched the influence, the harder to reverse. The longer no contact, more difficult to reunify. At the time from first signs to complete contact failure can be as little as three to four months. So we've got the ambulance at the bottom of the cliff; we need to act well before this, well before the fall off the top of the cliff.

From my experience of trying to help the person, and I may not know - obviously, we don't know everything that's going on, but I have been studying it quite intensively (indistinct). But there don't seem to be systems in place, and certainly not systems between - certainly not coordination between systems, and no clear pathways within or between family law, child welfare, and natural health and other systems.

Even couple counsellors back further, seem to not be well trained in our family systems, and don't often identify what's actually going on when this is actually going on. We've got the child support issue where the use of custody and visitation is used to fix the level of child support and can distort decision making about the welfare of the child and be a perverse incentive for one parent to deny the other extensive time to maximise their income.

And although grandparents, uncles, aunts, cousins, can provide a refuge from the chaotic home for the child, sometimes some of them align with one of the parents at break-up, and may even enable or even increase the alienation of the children who have (indistinct). So it's a population health, as I see it. So these children that are losing the contact to one parent experience - often have experienced in their home multiple adverse childhood experiences which are linked with their (indistinct) and often they've got, you know, mental illness in the family, family conflict, divorce, and child abuse, just to start with. There's four of the eight.

So they highly pre-exposed to lifetime mental health and physical health issues. So there's costs to the individual, community, and economy, and loss of the family resources; the financial in having to go to court, to try and just have some normal upbringing, and for both parents to fulfil their responsibility to assist the child in their development. It wastes a lot of emotional energy. There's time off work by the parent trying to navigate through the system, and then probably presenteeism because their probably preoccupied with the problem, and setting up and running two homes, of course.

Representing themselves often in court, because it's so expensive, and a lot of family lawyers aren't aware and don't have training in this area. The parent without contact often requires intensive, expensive, psychotherapy themselves because the complex PTSD they're suffering from the relationship, and the ongoing emotional abuse, often from using the child as the

weapon. So, the (indistinct) to health services, but also the police criminal justice system in the short-term and also the long-term.

And then there's the cost of transmission of this trauma into the next generation, with the repeated pattern, because often that's what then happens to the children that are being - not had the contact, grow up to often be alienated from their own children, and with ongoing issues. So, if (indistinct) the development of full-blown contact failure. Failings in budgets and court systems in handling these cases from induction to (indistinct), on social services, medical facilities, in the treating the child in the long-term, and of course other family members.

Also, from what I can see, and I've talked with a lot of groups, there seems to be a lot of suicide of males and females that have lost the contact in this way from their children, and - but it's not reflective in any statistic, because I think the reason for suicide isn't collected, but I'm not sure. So there's also that cost, and that's a really important link. Because there also is - has been reported self-harming and suicide sometimes of the children in their teens when they've been alienated or lost contact with one of - a previously loving parent that, you know, hasn't committed any crimes or abused them in any way.

So, I was looking at the cost of that and the cost of - then the kids get into trouble in their teens, on drugs and alcohol. You've got police, criminal, and juvenile justice and correction costs, and then loss of productivity in the next generation. So what's happening? Well, lots is happening on an international level, like - it's been going for about 30 odd years now, and it seems that it's been very slow. That's why I wanted to bring it up with your Inquiry.

So there is an international study group. There are useful codes to be used in the DSM-5 and the ICD, but they don't actually mention criminal alienation. However, the new ICD-11 is going to include criminal alienation as a term in the index, which is a little bit of a step forward. The University of Tasmania, there is some research going on in this area, and some people associated there just, in the last two months, published a book on understanding and managing criminal alienation. (Indistinct), which is good.

There are lots and lots of peer support and online websites of varying system content, but a lot of peer support, which is terrific. At the severe end, often it's recommended intervention is - that you might need to separate the person who's doing the alienation for a period of time from the child, so that - to try and heal the family, and there are some people that run some groups for that, but there's very little available in Australia.

There's an Eeny Meeny Miney Mo website that provides a bit of information, and For Kids Sake is doing a lot of work in this area. Brazil and Mexico have made some legal changes, and in Ireland there's just recently been some - a couple of counties - a couple of county councils have recognised criminal alienation as both a child welfare and a child protection issue. In Israel, there's a retired judge that's writing quite a lot on this subject, with some interesting suggestions.

So there are many gaps currently as a - I think I've said that. Parents need to go to court to fulfil the responsibilities to co-parent their children. This is a psychological emergency for the children and the targeted parent, or the parent whose contact is being stopped, and it's

important that there's early coordination between the family law, mental health, and child welfare system. Early.

There are particular issues for men who are victims of domestic - this domestic violence, because there are, as it says, a big imbalance between the services available for a man and the services available for a woman when they're in this situation, even though men are one in - one-third of the victims. So we need a population health approach. It's a population health issue as well as a child protection issue, and so we need prevention at various levels.

So we need to educate the public and potential alienators or, as they're sometimes called, null-adaptive gatekeepers. Perhaps a social impact campaign. Educating professionals who are in frequent contact with children, such as educators, medical staff, and nurses in day care who might see early signs. Need early identification and immediate therapeutic intervention for the child and the parents, when identified, and where necessary, immediate court intervention, including orders for contact and treatment for the child.

Whereas in Australia, most people are not able to go to court and list (indistinct) through mediation, which is a fantastic thing for families and couples where both want to work something out. But when one, or both, don't want to do that, then it's really a waste of time and used as a delaying tactic to enable, particularly by the resident parent, to further entrench their ideas into the child. There should be strict sanctions where a parent refuses to comply with court orders for contact and/or treatment, including fines or imprisonment. Someone has recommended that. I don't know about that.

All these things I'm raising have been suggested by various researchers in the field, and I'm raising them as things to be considered by the system. So, in Israel, interestingly, they are going to ask, you know, if the contact stops, what are the problems with contact, and they're moving to - because also we have a problem over here with allegations of domestic violence or child sexual assault that often have to be disproved before the parenting orders can be considered.

But they're looking at possibly, instead of having that parent prove, or the parent who has no contact having them prove that the residential parent is alienating the child, or facilitating the child under the subject of the objection, that the onus should be on the residential parent to prove that there are justifiable reasons for the cessation of the contact. Sorry, I messed up a couple of things there.

PROF KING: No, no.

ANONYMOUS: They're two separate issues.

PROF KING: Yes.

ANONYMOUS: They have identified three levels of severity; mild, moderate, and severe, with different interventions. So, for instance, the mild; admonish and educate the parents. For moderate, coaching and family therapy, and for severe, we move the children from the abusive home, or the abusive parent. But also people have pointed out that use of the mild sometimes lulls therapists and legal people into a false sense of security in that, just because

it's called mild doesn't mean it is mild, and that needs to be addressed immediately anyway, otherwise it could progress on to the others, and quite quickly.

So I'll just say a bit more about the population health approach. Primary prevention, focusing on the entire population and may be at risk of parent/child contact problems after separation. For the public, this is mostly - I'd never heard of it before 18 months ago, and lots of people I talk to have never heard of it, unless they say to me, well, that happened to me. That happened to me, that happened to a friend of mine, or that happened to me 50 years ago, or that happened to me 10 years ago, or it's happening to my sister now.

So unless you're actually involved, you usually don't hear about it. So we need this - the public need to be made aware of the problem well before people enter into relationships, or at least at the outset of their parenting, and we need - possible need campaigns within the press, the TV, social media, high school, youth movement, pre-marital training, religious organisations, and community organisations.

And then the secondary prevention, which is the early identification and intervention for at-risk problems with problematic parental behaviour, or if the child's displaying reaction to the parental (indistinct). They need to identify the children at risk, parents at risk, and the parental behaviours that indicate family strife, and then refer to properly trained professionals for advice and intervention.

And then tertiary intervention for that more severe end is - needs to be immediate, interdisciplinary and professional, and involve lawyers, judges, therapists, and social services. So the lawyers need to be made aware of the phenomenon, causes and effects, and just need to perhaps consider whether they need special training and licencing in order to deal with cases involving children, and that they might need to be - file applications for immediate orders for reinstatement of contact where it's already stopped, and so injunctions to prevent (indistinct) of the parents.

PROF KING: So would that be lawyers working in the family court system?

ANONYMOUS: Yes.

PROF KING: Yes.

ANONYMOUS: Well, I'm meaning family lawyers, because I think - although, I suppose lawyers working in the juvenile justice system might.

PROF KING: They might also, yes.

ANONYMOUS: I'm not sure what other matters would be considered in other - by other lawyers, apart from family lawyers.

PROF KING: Okay.

ANONYMOUS: And family judges, family court judges, and including the court - the other court, the Federal court that hears family law matters, need special training in order to deal

with contact and other cases. The termination of (indistinct) came only after immediate interim orders to prevent deterioration into full contact failure, and for reinstatement of contact where it has already failed.

And orders for contact need to be clear, specific, and unequivocal. Where necessary, orders should specify sanctions for non-compliance, including (indistinct) for contempt of court, and zero tolerance for non-compliance. Because what happens often - also, I've become aware that, as far as I understand, the Family Court do not - and I don't think the other courts do - do not actually monitor the outcomes from their judgments, and so they don't really know, as in - whereas in health, you know, we monitor some outcomes to see if we've been effective. So there hasn't, as I understand it, been monitoring of outcomes, and might be a good thing to do.

PROF KING: Yes. I think that the Family Court, that one of the parents would have to reapply to the court if they felt that the orders weren't being followed by the other parent.

ANONYMOUS: Exactly. That's right, and that all takes time and money, and another point that has been made is that while there's - there is enforcement for child support payments, there's no enforcement of court orders. That the parent does have to go back to court and wait a long time, during which time there's more damage to the child. And doing more damage to the child.

PROF KING: Thank you.

ANONYMOUS: Sorry, I just had a few other - - -

PROF KING: Yes. Please, yes.

ANONYMOUS: - - - (indistinct) social services, child protection. But now had the gatekeeping of true alienation by a parent and the maltreatment of the child. So the child protection officers; should they get involved, and if so, when? And the social workers, and also the mental health counselling therapeutic services need to be able to get proper assessment and advice or treatment for children, or referral to good treatment for children of parents immediately, not - because time is of the essence.

PROF KING: Yes.

ANONYMOUS: Sorry.

PROF KING: No. So, thank you for that. You're completely correct. It's an area we haven't looked at in the draft, but it is an important area, and it will be one that our team will follow up. Now, the degree to which we go into it for final, there are - unfortunately, there are a whole range of areas where we're not going to be able to get into enough detail in final. But interestingly, from my perspective, you said the different people who haven't heard of it before.

As you started, I thought, yes, that's something that I should have thought of, because my wife's cousin went through exactly what you're talking about and we were here main

supports, because she was an immigrant to Australia, and quite bad situation of - well, alienation or separation of the children, actually quite strong manipulation of the children in that situation. So I understand what you're talking about, and also the effect that it can have on the relevant - on the children as well as the relevant parent.

But as I said, I'm not sure the degree to which we'll be able to get into it in our final report, simply because we've had to draw boundaries. But it will be something that the staff will take a bit more of a look at.

ANONYMOUS: Okay.

PROF KING: Harvey, did you have anything? No. Okay. Well, thank you very much for that.

ANONYMOUS: Okay. Thank you. Could I just say one more thing?

PROF KING: Please. Yes. No, no. Fine.

ANONYMOUS: It's just a thought at the end, but maybe the national policies that are developed for mental health and suicide prevention at least, maybe they include something to do with this phenomenon as well, being as (indistinct).

PROF KING: Yes. Well, and I'm also thinking about the role of the Family Courts. As you mentioned, the training of the lawyers, the training of judges. And again, this is one where I'm talking from personal experience, so of course you have, as you said, the orders to go to mediation, and there are - on numerous occasions, because the Family Court judges prefer a mediated outcome, but - which doesn't work when one of the parties, one of the parent's is not interested.

But to get the relevant lawyers involved at that stage, but of course, if they don't have the training to recognise what's happening, and that there may actually be a child protection issue, then it can fall through the cracks.

ANONYMOUS: Yes. And sometimes they don't believe the man. This happens also.

PROF KING: Yes.

ANONYMOUS: (Indistinct).

PROF KING: And either parent can be the one who's engaging in the manipulation of the children.

ANONYMOUS: That's true. Yes. The other thing was that often, when it becomes severe, often the person who files does have - it seems that they do have a personality disorder in that (indistinct) or also (indistinct) and so I thought there has to be - there is a link there with what's happening, you know, people like Spectrum and Project Air that I did approach them.

PROF KING: Yes.

ANONYMOUS: But I don't know whether they're able to be involved. But the thing is that often people with some of these disorders don't want to have an (indistinct) because they don't think they need it.

PROF KING: Yes. Okay.

ANONYMOUS: Anyway.

PROF KING: No, thank you very much for that. Thank you for taking the time and talking to us.

ANONYMOUS: Yes. And I can put in a written submission for you.

PROF KING: Of course. Yes.

ANONYMOUS: I'll tidy it up a bit.

PROF KING: Please do so. Yes. Okay.

ANONYMOUS: Okay. Thank you.

PROF KING: Thank you. Bye.

ANONYMOUS: Thank you. Bye.

PROF KING: Okay. Sorry. I need to finish, don't I? Yes. I need to officially finish. We are officially finished for today. We'll reconvene tomorrow in Brisbane. So the transcript can go back off.

**MATTER ADJOURNED UNTIL
TUESDAY 3 DECEMBER 2019**