



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

MENTAL HEALTH INQUIRY PUBLIC HEARING

PROF STEPHEN KING, COMMISSIONER
MS JULIE ABRAMSON, COMMISSIONER

TRANSCRIPT OF PROCEEDINGS

AT MANTRA PANDANAS, 43 KNUCKEY STREET, DARWIN
ON MONDAY 24 FEBRUARY 2020

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PROF KING: Good morning, all. Welcome to the public hearings following the release of our draft report for the Productivity Commission’s inquiry into improving mental health in Australia. My name is Stephen King and I am one of the commissioners on this inquiry. My fellow commissioner here today with me is Julie Abramson.

Before we begin today’s proceedings I would like to acknowledge the Larrakia people, who are the traditional custodians of this land on which we are meeting, and pay 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 receive comments and feedback on the draft report. This hearing in Darwin is one of many around Australia, in all States and Territories, in both capital cities and regional areas. We will then be working towards completing a final report to the Government in May, having considered all the evidence presented at the hearings and in submissions, as well as other informal discussions.

Participants and those who have registered their interest in the inquiry will automatically be advised of the final reports released by Government, which may be up to 25 Parliamentary sitting days after completion.

We like to conduct all hearings in a reasonably informal manner, but I would like to remind participants that there are key structures in our legislation for how these hearings are legally backed, and a full transcript is being taken. For this reason, comments from the floor cannot be taken. The transcript today will be made available to participants and will be available from the Commission’s website following the hearings. Submissions are also available on the website.

Participants are not required to take an oath, but should be truthful in their remarks. Participants are welcome to comment on the issues raised in other submissions. I also ask participants to ensure their remarks are not defamatory of other parties. You are all free to enter and exit the room as you want, and if anyone needs a quiet space, feel free to exit the hearing. 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 the evacuation of this building, the evacuation tone “woop, woop, woop” will sound. Please exit the building and make your way to the assembly point located at the post office car park.

Our first participant today is Bob Napier. Bob, would you like to come up to the table and just state your name and any – what you’re representing for the transcript.

MR NAPIER: I’m not familiar with the words.

PROF KING: (Indistinct) can be just for the transcript.

MS ABRAMSON: Yes, just have a seat.

PROF KING: Have a seat.

MR NAPIER: I'd like to show you a couple of photographs to accentuate a point.

PROF KING: Yes, that's fine.

MS ABRAMSON: Do you want them - - -

PROF KING: Do you want them put on the record?

MS ABRAMSON: Because it's hard for us, because we're on transcript, Bob, it's hard for us if we don't put them in - - -

MR NAPIER: Well, I'd like it back if I can.

MS ABRAMSON: Yes.

PROF KING: That's all right, yes, we can do that, that's good.

MS ABRAMSON: Absolutely. If you send them in an electronic form, we can put them up with the transcript or the submission, looking at our end.

PROF KING: Okay. Now, are you – because you need to be on there because you need to be on transcript. So I can show you which photo we're up to - - -

MR NAPIER: The first photograph is the Mandorah Jetty car park, I listed 20 things to the information – to the CEO of infrastructure, 20 faults on the next farm, and I'm not a qualified civil engineer. He replied he couldn't – it was all professionally done and there couldn't possibly have been any faults.

MS ABRAMSON: Bob, this is part of your submission later on, so do you want to start with an opening statement for us about what your big issues are, and then we'll get to this as you go through your evidence.

MR NAPIER: My major concern is – my focus is about bullying, I have three other small items, from personal experience, I'd like to present. One is, as a social phobic, there does not appear to be any representative of social phobia. The nearest we get is Rajesh on Big Bang Theory, where he's unable to speak to women, as I similarly was as a young man.

Three years ago, it took me several months to pluck up the courage to be able to say – to ask a lady whether she might care to join me for a cup of coffee. At age 65 – I feel uncomfortable just talking about this, it's - - -

PROF KING: Take your time.

MR NAPIER: But because there's no recognition of this, the mental health groups, GROW Group, that sort of thing, you can see these people, they sit alone in a corner, and that's as much support as they get. That's as much as I'd like to say on that.

PROF KING: Yes.

MR NAPIER: Second, an ad on TV, we need more finance for one-to-one counselling for victims of bullying. Now, that's good, but I would strongly recommend victims of bullying be given an opportunity for group therapy. Bullying by itself is very psychologically isolating, and therapy is comforting, but in a group, the brain realises that you're not alone, and it's the psychological isolation that pushes people to suicide, that type of thing. And that's as much on that.

PROF KING: Yes.

MR NAPIER: Having been seriously bullied, left Western Australia, I was prescribed Ristadol, tiny little white pills, take one at night. I cut them in half, took the small half, the next afternoon down at the small swimming hole in the mouth of the creek with my little boy, I'm thinking I could put me foot on him, hold him under water, drown him, go for a walk down to the water's edge, come back and say that I found him like it.

Now, at the time that did not spring out as being obscene, because I was thinking how I could invert the lifestyles of those who had been bullying on a similar plane. Two nights later I took the slightly larger half, woke up an hour later, cruelly busting for a pee, it was really cruel. Then for the next hour I got more and more wound up, agitated, with strong imposing thoughts of strangling my little boy. I promptly tipped them all down the toilet.

Six weeks later I seen an article from a Dr David Healy in Wales stating people on antidepressants committing suicide and murder-suicide. About 10 years later I got computer literate, I looked it up, I got a printout, 62-year old man prescribed Paxil for anxiety, within 48 hours he's killed his wife, his daughter, his granddaughter and himself.

This copy I showed my next door neighbour Jennifer, within about 10 days she was dead, she was on Paxil, classified as an accidental overdose. I feel there's sufficient information there that there should be a major inquiry into the association of suicide and antidepressants. That's crap.

PROF KING: Yes.

MR NAPIER: In 1983 my de facto committed suicide. In 1993, as a result of all these things happening, it occurred to me that I was being blamed, and in the next 10 years I got 10 references. The fifth was, "We were told not to employ you, you've murdered her and made it look like suicide", the 10th, about March 1985 was, "I've been told three times not to employ you", shire clerk, "Don't employ him, he killed his wife". Until I was – a fella in the post office and the previous postmaster of my ex (indistinct).

I spent \$30,000-odd on lawyers and a private investigator, he concluded that unless you have a family QC, they can pursue you, pursue this through to the High Court, and then the High Court of Appeal when they appeal against any decision, and access to a Maori bike gang rugby team on a sense of fair play, you were totally powerless.

I told the sergeant what had been going on, and he was quite horrified. I said any given Friday night you can grab the ringleader for drunken driver, but he'll lose his licence and the whole lot (indistinct). He said, no, I've done that, he'll get his cronies to write to the Commissioner and he'll be getting transferred to some antisocial town, and he wasn't going to do that to his wife.

So when a police sergeant of a small town is powerless, that is something to be aware of.

MS ABRAMSON: Bob, do you want to go back to what you think we should be thinking about in terms of bullying or like the top of communications.

MR NAPIER: I'm getting to that, that's my background. I got to Darwin, I was prescribed the pills, the first two psychiatrists diagnosed me as paranoid psychosis, two weeks later delusions of persecution. They couldn't understand what I was talking about, they didn't believe it because my story was so bizarre. It'll make a B grade movie strip. Eventually diagnosed post-traumatic stress.

Now, these days I go to uni, my focus is on boys, I'm doing counselling, and I can – society is illiterate to what bullies do. And I've got sufficient, I believe, information to validate that bullying is an addiction, commonly acquired at a young age, the insufficiently attached infant. Some become angry, some become anxious.

It fits in what you were saying about the childhood mental – from sight, hearing.

PROF KING: Early sources of – so just to tell us, so you'd say bullying itself, so bullying can cause obviously stress, tension, mental illness, but you would say also that the bully themselves, the bullying is a symptom of their own mental illness.

MR NAPIER: Yes. As any addiction, pretty much.

PROF KING: Yes.

MR NAPIER: Their need to feel validated or to hide so that they're – even anorexia is classified as an addiction, I believe from what I've read. I read a book – Tim Field wrote a book, *The Bully In Sight*, about his own personal experience in middle age, and many other people's experience, and all say the just utter futility, the system just does not acknowledge what's going on. Therefore, you're powerless.

MS ABRAMSON: Thinking about our inquiry, what would you like us to be thinking about in terms of recommendations? Because the way our report process works is that

we'll put recommendations to Government about certain actions that we think need to be taken. So what would you – given your experience and what you've been thinking about, what would you look to see us recommending? Thinking about early childhood, what would you - - -

MR NAPIER: That's a pigeonhole.

MS ABRAMSON: Or the workplace?

MR NAPIER: We classify an affliction across society, the workplace is just one pigeonhole. I read through the transcripts for – it was quite sickening, because some people did not fit the dimensions. So they can be bullied to the point of whatever, because they don't - - -

MS ABRAMSON: I guess getting back to what Stephen started with though, you'd be urging us to think about what resources should be available to help the person who's actually the bully, so to change their behaviours.

PROF KING: The victim and also the bully themselves.

MS ABRAMSON: Yes, that's right.

MR NAPIER: My perspective is biased. The victims come first, second and third, because the bullies operate like German raiders, but the system doesn't acknowledge it, and they just - - -

MS ABRAMSON: You made that point in your submission quite powerfully, because you talk about the experience that the person who was – that was alleged to have been doing the bullying, actually didn't leave the job, everybody else left the job. That's kind of the point that you made.

MR NAPIER: Yes. Because the system is illiterate to what's actually going on.

MS ABRAMSON: Do you know, Bob, different States have different approaches to this, so in Victoria – I'm a lawyer by training, so in Victoria we actually have some very specific legislation which deals with bullying, and it's called Brodie's Law after a particular case. And some of the other States have that type of legislation as well. So the consequences of bullying as well, or the treatment and support of both the victim and the person who's perpetrating the bullying, do you have a view?

MR NAPIER: My biased opinion is the bullies that made that car park, that car park was like what the Monty Python crew have done, they were effectively unemployable. They couldn't be trusted to clean toilets.

PROF KING: I suggest obtain a copy of the photo, which you'll later send through electronically. Did you want to – just on that, Bob, did you want to just run quickly through? So you've got other examples here. So sorry - - -

MR NAPIER: That's the approach road, it's a straight hundred kilometre an hour country road, to a blind dead end corner that dips beneath the horizon, with access through a drain that's just not visible until you're right there. And the bottom right-hand where there's been a couple of potentially nasty accidents. Is an example.

In the far right-hand corner you should see there's a no entry sign.

PROF KING: Yes.

MR NAPIER: And there's each way arrows, and the centre top you should see there's two give way signs, people doing 60 kilometres an hour from the left-hand side of that entry point have to give way to the people driving through the no entry sign. And it's been like that for nearly two years. So we have a whole community and a council that have failed to be able to deal with that.

MS ABRAMSON: So is the basic concern you have, Bob, that the infrastructure is not being constructed properly, given what it's supposed to be doing? Is that the heart of what your concern is?

PROF KING: Similarly the fourth one you've got is - - -

MR NAPIER: It says "Access above two metres".

PROF KING: Yes. Certainly not two metres.

MR NAPIER: There's an end – that ends at 3.2 metres, at massive great rocks. What I'm saying is that we have all these people that are addicted to this opportunistic power grab with dysfunctional infrastructure. Signs to get into Mindil Beach.

PROF KING: Sorry, yes.

MR NAPIER: It's a bit dark, on the centre right there's a little sign.

PROF KING: Gardens, yes.

MR NAPIER: Yes, that's the one. That was the original sign, ladder and gate 6 centimetres and 6 centimetres, hidden behind a little tree. I nearly come to grief trying to turn around. So the Minister – the Shadow Minister said, "Well, that's a no-brainer", I sent him a photo, and that's what they put, behind a street sign, behind a clearway sign, behind a little tree.

MS ABRAMSON: So your concern is then about public safety and use of infrastructure with those particular examples that you've give us?

MR NAPIER: These people are academically qualified in appointed positions, and they're doing stuff that a 7-year old would do, which is consistent to the traits as listed by Cleckly and Hare under psychopaths.

PROF KING: So the final sheet that you want us to look at is the definition of antisocial personality disorder from the DSM – is it from the DSM-V?

MR NAPIER: Yes. I consider those traits are for a specific – from a professional psychological perspective, for a specific definition. But I feel that for the general public's purpose, that could be polished, so to speak. So there's an Australian-wide definition of being bullied, but in the school classrooms or domestic violence or the workplace.

PROF KING: Yes.

MR NAPIER: And the lack of empathy - - -

PROF KING: Lack of remorse.

MR NAPIER: Yes.

MS ABRAMSON: What would you like us to focus on for our inquiry? If you had to pick a key thing - - -

PROF KING: Just one thing.

MR NAPIER: Identifying what bullying is.

MS ABRAMSON: Yes.

MR NAPIER: Galileo tried to explain to the pope the world went around the sun, not vice versa, and that's how the system is with this bullying thing. They've got it from the wrong perspective.

MS ABRAMSON: So what would be that perspective, Bob?

MR NAPIER: Bullying is an addiction to the dopamine kick in intimidating somebody else for their own self-validation, then there's a second dopamine kick by being able to lie about it. This is all done with fMRI scans, by very clever people in universities. So I was quite - - -

PROF KING: The reference in your submission, and you've got really good referencing things - - -

MR NAPIER: It's quite clear that this is a fact of – the standard – there's a bit on the internet, a gay kid confronts the bully that's been really hammering on Facebook, whatever. Eventually the gay kid loses it, give him a couple of (indistinct). And the gay kid gets suspended for three weeks, the bully gets suspended for two weeks. Now, the currency of bullying is it's not financial, it's not functional purpose, it's about omnipotence, psychological gratification.

By punishing the gay kid three weeks, it's just elevated the bully, he's omnipotent over the victim.

MS ABRAMSON: No, I think we understand the point that you're making to us, Bob. It's a complex area, and with bullying, you know, we tend to look at it through a particular legal prism and we say, well, does that meet the definition, and if it does meet the definition, what are the consequences. But you're encouraging us to look more broadly at it.

PROF KING: Looking through that psychological lens.

MR NAPIER: That APA definition.

PROF KING: Yes.

MR NAPIER: Now, the APA, I can't remember the term for under 15, it makes reference in that to under 15s, they have three different categories, sort of mild, medium and hard core. But in the adult, there's no reference to that effect. But the book, they decide by age 40 they've mellowed off a bit, but commonly are very well known to the police and have spent a fair amount of time in jail.

Now, the people who've done that car park, they don't – never get touched, they're not seen, they're invisible, they're off the glass ceiling and they know how to operate the system. So we have a system that's full of these people. There's plenty of brilliant people out there, we've had a couple of CEOs that are brilliant people in the council where I just come from, and a couple more that - - -

PROF KING: Maybe not quite the same quality.

MR NAPIER: Seriously not very nice people.

PROF KING: Thank you for that, Bob.

MS ABRAMSON: No, I think we understand the point of view that you've brought to us, Bob, and thank you for taking the time to do that, and also for your submission.

PROF KING: Yes, I thought it was a very eye-opening read.

MS ABRAMSON: Yes, no, thank you.

PROF KING: Thank you. And I'll pass you back these.

MR NAPIER: I should say thank you for the opportunity, the opportunity that you might be able to do something where other people might be less impacted.

PROF KING: Yes. No, you want to make a difference. Now, do we contact the next person?

MS ABRAMSON: We do. Thank you, Bob.

PROF KING: Just for your own background, formally we're on transcript there, so we are taking a record of the conversation. Can I ask you to just identify yourself for the transcript initially, and your position, and then any opening comments that you'd like to make.

MS CLANCY: Okay, thank you. I'm Rosemary Clancy, I am a specialist clinical psychologist and a member of both the APS College of Clinical Psychologists and a member of the Australasian Sleep Association. I work at a (indistinct) suite at the Sydney Sleep Centre and also write on evidence-based insomnia treatments at the website www.letsleephappen.com.au and I also work as a clinical psychologist at the Sydney Clinic in Bronte, New South Wales. So have I covered - - -

PROF KING: Yes, that's good. And we've read your submission, post-draft submission, just briefly in a couple of – in a few words, what are the key messages you'd like to get across to us and what would you like us to be recommending to Government?

MS CLANCY: Yes. Okay, so my submission has basically two, prescribe and increase public understanding of the reciprocal relationship between poor sleep and poor mental health, insomnia features, and prescribing culture which accidentally fosters sleep medication dependence long term, and increases overdose risk (indistinct), and I'll be talking about BEACH data for that.

PROF KING: Yes.

MS CLANCY: Then finally, the cost effectiveness and evidence-based for CBT for insomnia, which ameliorates depression through sleep improvement.

PROF KING: Yes.

MS CLANCY: So should I say a little bit about the research behind it?

PROF KING: Yes. On the sleep CBT, that would be fantastic. CBTI, I think, is the way it's designated. But also, very keen – just for you to think of whilst making a comment, medication has come up as a recurring theme in these hearings and in our post-draft submissions, so I'd be very interested also in your views of whether there should be tighter controls on medication, is there over-prescribing. How do we actually deal – if that's an

issue, how we would recommend to Government to deal with it, I'd be very keen to get your opinion on that.

MS CLANCY: Yes, I'd certainly really like to weight into that debate, because the same thing came up at the Sleep Health Federal inquiry last February. So it's an ongoing question and issue, not just for this country but for all developed countries around the world. We see the same issues happening in the US, the UK, Denmark, Norway, France, Germany, Finland. There's a great deal of research into long-term habitual use of these types of medications.

MS ABRAMSON: Rosemary, it's Julie Abramson, I'm just confirming for the transcript, you're talking about the Senate inquiry into sleep health last year?

MS CLANCY: That's right. That's Greg Hunt presided over that. Yes. So I presented something sort of similar to that, but what I'm really focusing on here is the nexus between and the reciprocal relationship between poor sleep and poor mental health. So even if people won't self-disclose in emergency departments with suicidality, they will generally front up for sleep or chronic pain issues, and that's one way to capture them, when they're otherwise quite secretive about suicidality.

PROF KING: Yes.

MS CLANCY: Okay. So I'd like to say poor sleep, and there's just a little bit of the research that exposes an early warning sign of deteriorating mental health and a crisis warning sign of imminent suicide intent. And Shane (indistinct) and he won't disclose this to the emergency department to talk about concerns.

Insomnia is the most common sleep disorder, affecting up to 40 per cent of the population, features of stress and dissatisfaction with the quality or quantity, about initiating and maintaining sleep, frequent waking or problems resuming sleep after waking, or both, early morning waking, inability to resume sleep, and clinically significant distress or impairment in social, occupational, educational and other areas of functioning.

So it occurs at least three nights a week, for probably three months, despite adequate opportunity to sleep. So pre-existing insomnia is a primary factor for depression, 40 to 50 per cent of insomnia sufferers have a comorbid mental disorder, these people are 10 times more likely to have clinical depression and 17 times more likely to have clinical anxiety, and it starts early.

Paediatric research links children's sleep disturbance with anxiety and depression, especially a number of studies done in the UK. So poor sleep affects poor mental and physical health, and poor mental and physical health affects sleep.

The perceived go-to for sleep problems, that is prescription sleep meds, is found by the clinical research to complicate the picture further. According to the Victorian Coroner's Court sleep prescription medications are involved in 55 per cent of 284 overdose deaths in

2014, up from 49 per cent four years earlier. Thereafter the medications Xanax and Valium were moved to the Schedule 8 for restricted prescribed meds.

But what we've seen in the ABS 2016 data on drug-induced fatalities, which showed that benzodiazepines were the most common substance present in drug-induced deaths in 2016, being earlier provided at 653 of the deaths, or 36 per cent. And the most common substance in drug deaths soaring from 22 mid-60s, and the most common substance present in male deaths from (indistinct).

Now, the vast majority of these deaths are accidental. And this means that 440 of those 663 in Australia died accidentally from an overdose that features benzodiazepines. So those medications that they were prescribed for anxiety and insomnia, that they're prone to tolerance and addiction, they're particularly dangerous when taken with other substances, because they cause respiratory depression, and over 96 per cent of those drug deaths where they were present they were mixed with other drugs including alcohol.

So over a 20 year period, (indistinct) found that benzodiazepine dispensing in Australia, using drug utilisation in the Pharmaceutical Benefits Scheme data, shows that 174 million scripts were recorded, with Temazepam, which is prescribed for insomnia, the most dispensed benzodiazepine at 75 per cent.

PROF KING: So to the degree – just on that, Rosemary, to the degree that – I'm not making a judgement here, I'm not a clinician so I'm – what could we recommend to Government to do about that, recognising that GPs and psychiatrists have the training to dispense, have been given, in a sense, the legal mandate to write prescriptions – they don't dispense, sorry, they write the scripts – what should we be doing about this issue?

MS CLANCY: So the GP training it's (indistinct), because Temazepam, the BEACH Study, which I'm sure you know, the Bettering the Evaluation and Care of Health, looked at actual prescribing data of all the GPs and they found 90 per cent of patients presenting to a GP, that GP said, "you've got insomnia" and prescribed a hypnotic medication, and Temazepam is still the most preferred drug of primary care at 50 per cent.

So melatonin, which is – all GPs is less than 10 per cent prescribing. So the prescribing culture fosters easy availability of those medications. So it's an education issue, I think. And this is about – and the difficult years – you know, some insomnia features that cement this, and it's not just a prescriber's underestimation of the harm from this medication in the users, and because of the easy availability, they think it's just the norm or it's – there's not a health risk in popping these, and you don't know about respiratory depression issues. And they certainly don't really think about the way they misconstrue sleep and how the medication keeps maintaining that.

PROF KING: So do you see a part of the education of GPs is making them aware of CBTI as an alternative, a non-medicine-based alternative?

MS CLANCY: Look, that's my primary goal. I think this is really important, because many GPs and patients come to me for the psychological treatment that RACGP is stating that should be first line treatment in (indistinct) prescribing guidelines, and the patients say that they started on the medication as a way of short circuiting the insomnia habit, but the phrase itself is erroneous. You're not short circuiting an insomnia habit, you're just grasping a pill taking habit, which is far more convenient, onto an insomnia habit and maintaining that.

MS ABRAMSON: It's Julie. One thing that we also need to think about though is patient education, because when we speak to GPs about this, they'll say to you that people can be very insistent that that's the drug that they want. So it seems to me there's two parts to this, not just GP education, but community education.

MS CLANCY: Right, yes. Look, I mean, this is – and there should be two prongs to this, it's a gateway really I suppose to why I have a focus on the GP education and training. And also because I'm a member of the Australasian Sleep Association, and it was a prominent issue at the Federal Sleep Health Inquiry.

PROF KING: Just to get your opinion on – I mean, just purely factual. When Better Access came in, and one of the other Commissioners on our inquiry, Harvey Whiteford, was involved in the initial setup for Better Access, and he quite willingly admits that originally they thought there would be a significant drop in the prescription of medications for mental health, and what they found was the introduction of psychological therapy through Better Access, MBS-subsidised psychological therapy to Better Access, had almost no effect on medication rates whatsoever.

So what the GPs started doing was both writing the scripts and recommending that you go and see a psychologist of the person for CBT. So do you see that as being a problem here as well?

MS CLANCY: Yes. Look, there's a couple of parts to this. One is that most psychologists, even though they say they're religious in sleep hygiene interventions, and the problem with insomnia, once it becomes an issue and threatens to be chronic, is that people know very well what the sleep hygiene rules are and in fact they might keep to them too closely and that actually creates performance anxiety about sleep.

So CBTI is about not – well, sorry, it's about valuing sleep but not over-valuing sleep, and most psychologists don't actually have training in CBTI so they don't actually grasp that part. So yes, there is a need for better information to be out there, and this isn't the sort of information that can be encapsulated very quickly and easily on websites, because most people, it actually sounds quite paradoxical to people, that you could be trying so hard to problem solve sleep, but you actually make it worse.

So the difficulty with the medications in particular is because they seem like a go-to because they're cause anterograde amnesia. The hypnotic medications in particular starts with the anterograde amnesia, which is a welcome benefit, by a patient.

MS ABRAMSON: Could I just ask, Rosemary, I don't know what this is. What is that amnesia that you've just spoken about?

MS CLANCY: Yes, so just – so I mentioned that – anterograde amnesia is that while the medication is active you're not laying down your memory, or laying down your memory in bed. It particularly affects dream sleep, or REM sleep, which is important for memory consolidation.

Now, all the major benzodiazepine and BZRA manufacturers warn consumers of confusion and memory loss side effects from the product. Even Mayer the manufacturer of the new sleep medication, (indistinct), which was hoped to be an antidote for the dependence – widespread dependence on benzodiazepines, even that warned prospective users of memory loss on the medication. And this matches insomnia sufferers' perceived need, because in insomnia we have biased recall breaking through the night.

We're very poor judges of time, and 11 minutes awake on polysomnography data as a sleep study will routinely feel like over an hour of wakefulness. So the amnesia and sedation feels to users like a solid night's sleep, but it's only cessation and memory loss.

MS ABRAMSON: Yes. No, I understand, thanks.

PROF KING: Can I just – sorry, final one from me is - - -

MS CLANCY: That's people would be clamouring for the medication though because they feared (indistinct).

MS ABRAMSON: Yes, understand.

PROF KING: Quick answer. So CBT – to get access to Better Access at the moment you need a mental health treatment plan from your GP, formally it covers CBT, do people access CBTI – well, we know that people access things more than just straight vanilla CBT through Better Access. Do people access CBTI through Better Access at the moment, or is that very unusual? Because I can't - - -

MS CLANCY: Yes. Look, this is – there's a paucity of CBTI trained psychologists in Australia. So that's a (indistinct) too. And it's also – because I work here in a psychiatric hospital setting here four days a week, we are not doing sleep interventions, and – we actually do sleep interventions here too. So many of our psychologists and also interns coming through are really focused on therapies like – like CBT and acceptance commitment therapy, and are not necessarily interested in sleep as a specialty. And I suppose it might be an issue too for psychiatry.

So yes, there's – I certainly have numbers but they're – so there are more and more GPs, especially in the Sydney area where I practice, are aware of the evidence base of CBTI and so they're preferentially referring for CBTI.

MS ABRAMSON: It's Julie, thank you very much, Rosemary. We've had a number of presentations and submissions about sleep, so we're certainly thinking about it in the context of our final report. It's not something that we picked up earlier. So your evidence today adds to the weight of a number of very eminent people who've spoken to us.

MS CLANCY: Thank you.

PROF KING: Thanks, Rosemary.

MS ABRAMSON: Thank you very much.

PROF KING: Would you be able to start by stating your name, affiliation just for the transcript and any opening comments that you'd like to make?

MS SPENCER: Sure. I have a piece of paper that I've brought that will be important to me. My name's Linda Spencer, and I became aware of the Productivity Commission through - - -

MS ABRAMSON: You can take a seat.

PROF KING: Please don't stand.

MS SPENCER: You know, standing is nice when you sit all day.

MS ABRAMSON: We're very informal – you're on transcript, but we're quite informal.

MS SPENCER: Great, thanks. So I became aware of the Productivity Commission through the Australian Counselling Association, and I'm a registered counsellor with the Australian Counselling Association.

I feel like there's a lot I want to say, but I brought a little bit of a list that I'll probably like to expand on. So I moved – it's going to be Territory-specific, but I've also lived in Victoria for many years working in the mental health field down there as well, and mental health and drug and alcohol. So my speciality is dual diagnosis.

So one of the things that I've noticed, particularly in the Northern Territory, is community awareness of available services and access to services, particularly in remote communities, is lacking, and I think that would be a really helpful thing to be able to educate communities about how they can access service when there's a crisis, particularly in the more remote communities, but definitely in Darwin as well.

There's a real gap for adults with serious mental health that aren't in crisis. So up here it's called ATAPS and in Victoria it's called VHN. So access to psychological services through ATAPS is – I think it's between six and 10 sessions. I don't have the numbers exactly, but

yes, I believe it's something like that, which is really great for early intervention or a less chronic mental health.

But with the serious mental health issues it really – it's just not enough, and there's nothing in between that and then when you look at the mental health services in Darwin, they're really designed around managing crises, because there's just not enough service to go around, and so there's this whole realm of people that it's having a massive impact on the community and their families and the quality of life, which just is not addressed, I feel.

When I was in Victoria I had a private practice and as a registered level 4 clinical counsellor with the ACA, I could register with one of the cooperatives, if you like, and then be referred clients through the PHN process, up here my understanding is that doesn't happen. So ACA registered counsellors can't be available through the ATAPS process, which seems ironic, given that in Darwin there's even more of a lack of services than there was in rural Victoria.

The other thing that I also wanted to say is that I used to work as a provisional psychologist and was doing that for four and a half years before I transferred over to Australian Counselling Association. And I feel like I've got a lot of respect of psychology, I love the discipline, and social work and also counselling, obviously, and I feel like there needs to be – what I say to my clients is that not every counsellor or every psychologist is right for every client, and that you've got to find one that you really resonate with.

Personally I feel like counselling and psychology is one of the most intimate things you could ever do. You're really becoming quite vulnerable in a session and able to move through your challenges and explore a different way of being. So I think it's really important that there is a myriad of people and disciplines available for the myriad of people that are wanting to access services.

That's not to discredit psychology or social work in any way, shape or form, but it's just to say that even – all disciplines aren't right for every person. So I really feel like it's a big missing to not be able to provide that through the ATAPS process.

I do work for a community health organisation, I'm not representing them today, but I really see that community health organisations are in a really unique position to be able to provide that gap for people with serious mental health illness, so that they're able then to take on the ongoing long-term counselling for the complex mental health that aren't at the pointy end and needing the hospital intervention.

MS ABRAMSON: Can I ask, are any of the clients that you're working with in the NDIS? We know there's a huge cobble of people that aren't, but just kind of interested, because you talked about the severe end, so what sort of percentage of the client base that you work with have got NDIS support?

MS SPENCER: You know what, I couldn't really say off the top of my head, but they're certainly there. Being psychology trained, I love data, and I doubt my own sort of

guesstimates, so I think if I was to have a guess I'd probably say about 15 per cent of the caseload I have now might be NDIS eligible, and I've certainly done treatment summaries to support, successfully, clients accessing the NDIS.

The difficulty with the NDIS as well, particularly for mental health, is that you might be able to get them connected to NDIS and get all the services agreed upon, but then getting the locals who want to work with that person, particularly when you're in a small community, can be challenging.

PROF KING: Can I just follow up on exactly that point? So I think one of the – we've had a number of meetings and hearings and visits to the Northern Territory, and the thing that strikes me is everyone's aware of the need, and some of the submissions put to us, "Look, we just need more funding and things will be right", I think what strikes me though is what we really need is some people. And have you got any suggestions for us, because, you know, and I don't know how this - I don't know what to recommend to government to solve a problem that simply the workforce here, the counsellors, the psychologists, the peer workers, that entire workforce, it's simply far too small to deal with the issues here in the territory. I don't know how we can fix that so if you've got any suggestions?

MS SPENCER: That's a really, really great question and I'm really glad that you're asking it and hopefully you're asking that on a really broad basis, which I'm sure you are.

PROF KING: Yes.

MS SPENCER: I can really only speak personally, so I moved up here with my husband two years ago. He's been wanting to move up here over 20 years and the planets aligned and I said, 'Let's do it'. When we moved it was incredibly financially challenging and also, you know, as you can imagine there's a lot of changes. I'm 50 this year. So there was - even though I'm moving into an area that has great need, there was no financial support for me to do that and the financial support that's available with the government now is along the lines of if you're a sort of family breeding age, if you like, in the hop that they're going to set up family here.

MS ABRAMSON: So that would be territory specific assistance from the Territory Government to encourage migration?

MS SPENCER: Yes, or, I mean, why not ask federal support as well, really.

MS ABRAMSON: We might have a view about that.

MS SPENCER: Yes, but that's true but we're all part of this big country and the territory is a vulnerable citizen, so, you know, one would hope there would be a bit more support in light of that. So the job I had I was working in private practice but I also was employed and I was employed for the same organisation for eight years so you can see that I'm quite stable in my employment history, and I've been with the same organisation since I moved

up here at the start of 2018. So I feel like if that support for people to move up here was extended to the middle aged population and - - -

MS ABRAMSON: You are amongst friends.

MS SPENCER: Even older, you know, like this is potentially a great place to retire. My only concern is the health services and I can see that that would be the only reason we'd move away.

MS ABRAMSON: Can I ask a question about mental health literacy in communities? So as Stephen was saying there's a workforce shortage which doesn't have easy answers to it, but what about mental health literacy amongst communities, especially given where you are? I'm looking at Matt whose question it was, so hopefully I've got it right.

MS SPENCER: Yes. What was that question that - - -

MS ABRAMSON: It was about mental health literacy in communities?

MS SPENCER: Okay so I will just be really transparent here, I'm based in Palmerston.

MS ABRAMSON: Yes.

MS SPENCER: I do sometimes provide supervision and support for Tennant Creek. Personally I think we really need to work with who we've got in the communities, and the way that you'd work with a community wouldn't be the way you'd work with one in a city, if that makes sense?

PROF KING: Yes.

MS ABRAMSON: Yes, absolutely.

MS SPENCER: You have to make allowances. So in terms of the health literacy I think I can only speak from the staff's perspective, and that can vary. That can vary. So that what I've noticed too is that in communities the demand on the services is enormous which creates its own issues around recording and meeting requirements for funding bodies, and things like that.

MS ABRAMSON: Do you think are there any particular gaps in the provision of youth services here or is it just general gaps through the whole cohort of people who need mental health support?

MS SPENCER: In our office there's a real gap for the adults. We have just had a youth mental health service team start, which is two, a case manager and a case manager/counsellor, if you like, for the serious mental illness that's not at the pointy end and needing crisis intervention. We don't have that for adults. And we've also got a drug and alcohol team specific for youth as well, yes.

PROF KING: Thank you, for coming in today.

MS SPENCER: No worries.

MS ABRAMSON: Thank you for making the effort to be here today.

PROF KING: Yes, thank you. The next one we're doing is by phone.

MS ABRAMSON: By phone.

MR VAN DER SMAN: My name is Jos Van Der Smán and I live at Lilydale in Melbourne and I've been a bipolar sufferer for about 40 years and my story is how well I've coped without medication, which I'm doing currently.

PROF KING: So do you mind just very quickly summarising, you were placed on medication as I understand when you were quite young, at 21?

MR VAN DER SMAN: That's right.

PROF KING: And then you found that even though you felt that you could function better without the medication you had issues with the doctors, can you just briefly run through those?

MR VAN DER SMAN: Yes, basically when I brought up the subject of reducing my medication because I no longer required a full dosage there was no discussion about that, they just said, 'You have to take it for the rest of your life and we can't talk about it because it probably won't work if you are taken off the medication'.

PROF KING: And was that just one psychiatrist or one GP, or was it a range of - - -

MR VAN DER SMAN: Yes, it was several, two or three psychiatrists.

PROF KING: Okay so as I understand it you've now gone off the Lithium?

MR VAN DER SMAN: That's right.

PROF KING: How did you do that as I understand there can be medical consequences - I'm not a doctor, by the way, so it's very much second or third hand, as I understand there are potential risks of going off medication, so how did you manage that process, was there any support for you?

MR VAN DER SMAN: There was no support for me so I had to make it up as I went along and I just gradually withdrew the dosage.

PROF KING: What feedback did you get from your GP, your psychiatrist, whilst you were doing that?

MR VAN DER SMAN: They were not aware that I was doing it.

PROF KING: Were you seeing the GP or psychiatrist whilst you were withdrawing from the medication, you said they weren't aware, does that mean they didn't notice any change in your clinical symptoms?

MR VAN DER SMAN: I think I'd stopped seeing them about the same time taking myself off medication.

PROF KING: So this is a number of years ago, I understand, so around 1983?

MR VAN DER SMAN: That's right.

PROF KING: That you downsized, and are you completely off the medication now?

MR VAN DER SMAN: Yes, I have been since 1983.

PROF KING: How, well, first, are you a - do you continue to have symptoms, if so, how do you manage them, or are you - I'm trying to remember - do you have no symptoms, asymptomatic, I think is the word, but how is that going?

MR VAN DER SMAN: Yes, I have occasional symptoms but with bipolar you can get highs or lows, I was mainly getting highs, and I was managing them by a change in lifestyle and making sure I'm physically tired and making sure I have enough sleep.

PROF KING: So is sleep a key part of just maintaining your health?

MR VAN DER SMAN: Yes, it is.

MS ABRAMSON: Jos, it's Julie Abramson, there are a number of support groups now available for people with particular disorders, so you made the decision personally to come off the medication, is there a way that people could be provided with support through, you know, some of the sort of consumer led organisations?

MR VAN DER SMAN: I was in a support group called Grow and that met about once a month but no one else in that group was doing the same thing as me so I felt quite isolated from them.

PROF KING: Sorry, when you say doing the same thing as you, you mean - - -

MR VAN DER SMAN: Reducing my medication.

PROF KING: Okay, but it was the other people in the group were also had bipolar or it was a - - -

MR VAN DER SMAN: Yes, some of them did, yes. Yes.

MS ABRAMSON: And one of the reasons I was asking is we're very aware of the importance of the consumers being at the centre of mental health services so we're quite interested in how we could provide support for people in that consumer set. So it's not a medical intervention it's really about giving people support in the community, which is why I was asking about support groups.

MR VAN DER SMAN: Yes, that's right. And I think that my case shows that it is possible to do what I did.

MS ABRAMSON: Yes.

MR VAN DER SMAN: But with support I would have been a lot better off (indistinct) of saying that.

MS ABRAMSON: And Jos, what would that support have looked like?

MR VAN DER SMAN: Basically an agreement that I'd have my dosage reassessed and then depending on that assessment whether it would be suitable for me to reduce my dosage or not.

MS ABRAMSON: Do you feel in the intervening years that things may have changed, that as I think Stephen said, it was 1983 when you began that journey, do you think that there is a more openness amongst clinicians now?

MR VAN DER SMAN: I'm not sure because I haven't seen a psychiatrist since then.

MS ABRAMSON: Yes.

MR VAN DER SMAN: So I'm unaware of current treatments.

PROF KING: Now we're obviously making recommendations to government and I notice that one of your points relates to psychiatrists and their procedures with medication, medication has come up as an important issue in a whole range of areas; the issues of over medication; the difficulty of getting advice to try and lower doses of medication; you suggested as I understand psychiatrists have procedures, do you think that would be enough or what more do we need to think about other than advising the psychiatrists?

MR VAN DER SMAN: Yes, I think the protocols need to be changed. Where at the moment psychiatrists may think, right, I've got this patient on the right dose, I'm going to stay him sticking there and leave him there because I know that works for him. And they

need to re-evaluate their procedures to the extent that by putting the patient first they will be happy to reassess the patient even though the patient is unhappy where he is.

PROF KING: All right. Julie, anything else?

MS ABRAMSON: Just thank you for sharing your story with us. As I said, one of the most important things in this inquiry is that people with lived experience have the opportunity to contribute and we know it's not easy to do that so thank you for taking the time to talk with us?

MR VAN DER SMAN: Thank you, and if there is an ongoing inquiry or a follow up for the medical profession I'm happy to participate in a meaningful way.

PROF KING: That would be fantastic, Jos, so thank you, very much.

MR VAN DER SMAN: Thank you, very much. Goodbye.

PROF KING: Hi, is that Philip?

MR BENJAMIN: It is.

PROF KING: Hi Philip. Stephen King and Julie Abramson from the Productivity Commission. Thanks for joining us. We are on transcript because it is a public hearing. So if we can start off, if you could just state your name and any affiliation for the transcript, and then any opening comments you'd like to make.

MR BENJAMIN: Thank you, yes. I am Philip Benjamin. I'm not appearing on anyone's behalf except my own. I have mental health experience and I have been working in mental health for 45 years. I am employed in Queensland, but I'm not representing Queensland Health support.

PROF KING: No, understand, yes.

MR BENJAMIN: Yes. So I've been in Melbourne since the 70s at Larundel Hospital, and was lucky enough to get some training in psychotherapy during that period, which has kept me in very good stead. I've been working in what is now called community care centre; at that time it was called productive teams since 1996, for a brief period when I worked at the education unit.

I actually sat on the Board of Trustees for Inwood, which is an international organisation supporting the hearing voices mental health, the hearing voices approach. I'm not sure if you're familiar with that, but very interesting approach to experiences people have when they hear other voices.

PROF KING: Yes. Early on in the inquiry, we had some evidence presented on hearing voices, or the hearing voices approach, yes.

MR BENJAMIN: Excellent. So the reason I'm interested in contributing to the Commission is - I had a scan through the report; I'm sorry I haven't been able to read it all.

PROF KING: It's very long.

MR BENJAMIN: It is, yes. I just searched for the word "trauma" and noted that really the only references to trauma in a systematic way were the ones who had experienced it. But I soon realised, after I began working, the emergency department back in Melbourne, a lot of people who didn't make it through to the mental healthcare system because they weren't deemed seriously sick enough. They'd experienced a lot of trauma in their lives.

PROF KING: Yes.

MR BENJAMIN: Which when you start looking at it, it soon became obvious when you look at the data particularly Defence people with serious mental illness, that they've experienced trauma.

PROF KING: Yes.

MR BENJAMIN: So I expect there is a protect when I was studying for a masters at Monash in the mid to late-90s. Just that the clinician is helpless when discussing past sexual abuse particularly, and with the result, and not surprisingly, assistance of clinicians, they're not able to respond or even enquire about past trauma. So it's become a hobbyhorse of mine in a way.

PROF KING: Sorry, can you just back-up there, just one second. So with regards to clinicians enquiring into past trauma, can you - - -

MR BENJAMIN: You want some more detail on that?

PROF KING: Yes, please.

MR BENJAMIN: Okay. Well, at the time I was working at Northwestern Health in Melbourne. And I accidentally came across a policy which was called – a policy about past sexual abuse. In fact a policy about the enquiry about past sexual abuse. And as I was studying for the master's at the time and looking for a research project, I found a tool that was developed by some mental health nurses in Montreal, and had been known as the sexual abuse compass scope.

And I managed to get consent from the organisation, actually it was fortuitous because I'd applied to the Director of Mental Health at the time. I could see him balk at the idea of inquiring about past sexual abuse, and it occurred to me that this man had probably had some experience himself previously. I knew the authority quite well and he was in the room at the time, and I was able to adduce support to produce a – to go into that research.

PROF KING: Yes.

MR BENJAMIN: So I emailed out a digital copy of the film, which was really asking about how comfortable people are. What was interesting, the results went up statistically significant, and what was apparent was that the longer that a clinician had been working - and that didn't depend on their age, but their duration of service - the more comfortable they were. But the nurses and doctors were much more comfortable, ironically, than psychologists and social workers.

But still, the levels of comfort were very low.

PROF KING: Okay. I mean, it's an important point because we've heard a lot during this inquiry about the importance of trauma-informed care. I recognise I'm not a clinician but there appears to be different views in the literature about the degree to which mental health issues (inaudible) or issues are currently occurring.

MR BENJAMIN: My reading of the literature is that people who are exposed to trauma as adults are much more vulnerable to those experiences, if they have had trauma or neglect in their childhood. I mean, in fact, I'm sure you're familiar with the age of the study, which was done by a (indistinct) in the 1990s in the United States, and there's somewhere like 60,000 enrollees in their issue.

And what they determined was that there was a balance who did they affect, which is in a sense common sense and so when you try and identify the effects, they'd be very personal; you know, some people obviously take trauma in their stride and others are devastated but it. Some people are able to use it as a leverage point to improve their health and make a significant contribution, like people like Cathy (indistinct) but with others, they're devastated and clearly, never recover.

What I do clinically - and I still work in emergency departments in Brisbane - a lot of people who are having problems to deal with, starting with me, have had some really terrible experiences in their lives, and I'm wondering what might've happened to you. And that's not a direct question, but it's an assertion of my view and I just miss the point but really often, because - and when you look at the literature, the evidence is that people are more traumatised when they go through these experiences.

I had a woman in the emergency department in Brisbane just a few days ago who told me that she had been sexually abused by a cousin, from the ages of five to seven. And when she told her mother, the mother had continued to allow this child, this cousin of hers, to visit the house. And so there's betrayal in a sense. And the mother had her own mental health issues. The father in this situation was a very violent alcoholic and the mother was suffering from her own mental health problems.

But I think the reality is that the situation, because it provides no opportunity for people to recover. And so one of the points I wanted to make to you was in my view, the diagnostic criteria only tends to be relevant to various people. My own view is that the most important

measure is complexity. If we have someone who presents with some stress that's caused by an incident and they don't have a complete social situation or background, there's nothing you could do with them, and these are the people who are probably still in the mental healthcare plan approach, where you get, you know, ten seconds, whatever it is.

PROF KING: Yes.

MR BENJAMIN: Sit down with a counsellor who has appropriate training but if you've got a complex background, that's a completely worthless exercise because the standard CBT model (indistinct) put up with, only those who've experienced it. Like, it doesn't help them at all, these are some bigger issues.

PROF KING: Yes. I'm married to a psychologist, so as well as the information from here, I've been informed CBT is useless for trauma.

MR BENJAMIN: Yes. And it (indistinct) but if you're saying to someone, "Just change the way you think about a situation," they're (indistinct) I mean, I think in a sense - my background is from a Jewish family, and my brother-in-law's mother is an Auschwitz survivor; she's now 99. And so I've grown up with people who have survived clear trauma, and to me, it's the reality that they don't forget.

The experiences are embedded in their daily experiences. People are triggered by the most minor things, you know? I mean, pressures of someone walking past can be a significant trigger. And I wanted to think that – interestingly I was going to bring up – I belong to an email discussion and recently - not in the context of the murder/suicide in Brisbane this last week, but in terms of – in general terms of people's human rights.

There was a couple of clinicians from Australia who described their clients' experiences – particularly two women who were described with horrific experiences of abuse from neglect in childhood, and some trivial incident were tackled to the ground by a group of usually big tough men who proceeded to manhandle her into an isolation cell, which is really what the treatment was about.

Different (indistinct) subjected her - and left her naked in this room for a period of hours. And they used a really really traumatising experience.

PROF KING: Can I ask you then, just we're obviously making recommendations to government.

MR BENJAMIN: Yes.

PROF KING: And obviously a key issue on the clinical side is trauma, re-traumatisation, making sure that the appropriate care for people who have trauma-based mental health issues is available. In a sense, we're sort of covering-off on those, so we're recommending that the access to psychological therapy be expanded, initially on a trial basis, and cover things like EMDR and other appropriate approaches to deal with trauma.

MR BENJAMIN: Yes.

PROF KING: What else would you like us to recommend to government? If you had one thing you want us to say, "Government, you should be doing this," what is it?

MR BENJAMIN: It is a national (indistinct) of two things; one is - I should've mentioned it a minute ago - one is that I was lucky enough to be in (indistinct) for the last year in September at a conference, and I'm not (indistinct)

PROF KING: Yes. No, no.

MR BENJAMIN: Okay. So they have an annual conference, and last year's conference was focused on human rights. And there were some presentations by people running pilot projects in Europe, where the emphasis is on the idea that people's illnesses are derived from an abuse of their human rights and therefore, the only rational response is to act in a way that reinstates their human rights.

But a number of presentations where the services had opened their doors and were imposing on people to be - and in fact (indistinct) for hospitalisation (indistinct) they had, in fact, closed all their mental health services, all their in-patient services (indistinct) but what I was going to say was that there was more than (indistinct) the World Health Organisation, exactly (indistinct) from Sydney and (indistinct) and the chair and her team have developed an online training program called Quality Rights, and they've rolled it out in some jurisdictions in Africa and noticed a significant improvement in the application of human rights.

MS ABRAMSON: Phillip, it's Julie Adamson. What was that lady's surname? It was Michelle?

MR BENJAMIN: S-u-n-k

MS ABRAMSON: Thank you.

MR BENJAMIN: So she's a very sophisticated thinker and this – I've had a look at it myself, and I was very impressed with what she does for the World Health Organisation website or I can send a link, if you like.

PROF KING: No, we'll follow-up on that. But you did say there were two things that you wanted.

MR BENJAMIN: Yes.

PROF KING: What's the second?

MR BENJAMIN: When I was (indistinct) not fair. When I worked on the Sunshine Coast, I did some (indistinct) in community mental health, so I worked on a ward in Nambour. And (indistinct) was in there, because so many of these wards are staffed by people who use - completely contrary to mine in the way the people can be cared for (indistinct) use that approach.

And I was very impressed. There were two English trained mental health nurses; one was CMC, one was the educator. And they had taken nothing but (indistinct) to them for (indistinct) reduction programs, which was in 2014 I think, or 13. And they had taken all the staff on their ward offline and given them some real (indistinct) there. And he had (indistinct) there, there was one (indistinct) and then after three years, most of the staff had moved on, there was a new unit manager and I wasn't working there at the time, but she was quoted to me as having said, "The problem we have in this ward is, we don't use our (indistinct) which is a long-term highly-sedating anti-psychotic, if I can use that term.

I mean, none of them are really anti-psychotics. Until you become aware of that, they're all just tranquilisers. And we don't (indistinct) enough inclusion. So (indistinct) said all staff, because one of the (indistinct) trends about to increase it (indistinct) everyone has quality rights across the nation. I think they'd be huge (indistinct) understanding it.

PROF KING: Aware of the time. Can I please thank you very much for your testimony here today? I found it very useful, so thank you.

MR BENJAMIN: Yes. I think the other thing that I might mention is that - I'm not sure (indistinct) public policy (indistinct) communication I think, at ANU. But he was the senator, public health in South Australia in the 80s, and in 2008 he presented (indistinct) and he - it was public policy for South Aussies. I remember being a fan of the - even South Aussies (indistinct) according to (indistinct)

And that is that the benefits that accrue from some policy decisions accrue in a different jurisdiction or a different department in public health, so you get this approach that people don't - you know, through all the - - -

PROF KING: Yes, they don't co-ordinate across jurisdictions, because, "I'm not going to spend money in my jurisdiction when you get the benefits."

MR BENJAMIN: Exactly.

PROF KING: Yes, we're well and truly aware of that, and particularly - well, in a federation like Australia.

MR BENJAMIN: Exactly. I mean, the other thing that I wanted to raise with you is there was a research project in Sydney in the early-80s (indistinct) and Allen Rosen was involved in that at the time, where they randomised people (indistinct) was the Director of Macquarie Hospital at the start. They recognised people for home treatment and in-patient care, on

the basis that people (indistinct) important predictors for people being admitted to hospital wasn't going to (indistinct)

And they did a randomised control (indistinct) and the results were outstanding. And that was the beginning of the model that we now (indistinct) to care. However, the facility that involved has been completely off. That's actually a home-treatment service, and I'm sure you (indistinct) as well, which is also a home-based treatment service.

The evidence (indistinct) is that home-based care is much more cost-effective and much more clinically effective than pulling people out. There is a society in Sydney called (indistinct) professional men, I think mostly who are (indistinct) developing open-dialogue in Australia, and we (indistinct) some open cases which actually demonstrated that in a family system, often people in home-based care, even though it's much more intensive (indistinct) in a way, but if you offer intense intervention early on - and this (indistinct) the model (indistinct)

Where you get much (indistinct) down the track. And so I think the first thing I would say to government is that what's really necessary is implementing home-treatment teams, not (indistinct) so the people are able to engage with their families. I mean, I really like to forward this full paper to you, because I think it's very important; so perhaps I can do it to one of the people who have emailed me?

PROF KING: Yes, please do, to any of the team members that you've been in contact with.

MR BENJAMIN: I've got Matt and Erin's emails, so I'll forward that to them.

PROF KING: Yes, that would be fantastic. And again, we have seen quite a bit of evidence on the benefits of keeping people out of institutionalised care.

MR BENJAMIN: Yes. I mean, one view is that in many cases, schizophrenia is probably a genetic disorder.

MS ABRAMSON: I should say - it's Julie Abramson.

MR BENJAMIN: Yes.

MS ABRAMSON: We've also got a recommendation: we'd like private health insurers to be able to do more in the community; so that is about providing home-treatment. So certainly, very (indistinct) of that.

MR BENJAMIN: Yes.

MS ABRAMSON: But thank you for taking the time. It's really been incredibly valuable, because you've been at the coalface of mental health service delivery. So thank you so much.

MR BENJAMIN: It's been my pleasure. And if there's anything I could do to help in the future, please let me know.

MS ABRAMSON: Thank you.

PROF KING: Thank you.

MS ABRAMSON: Thanks very much.

MR BENJAMIN: Yes, thank you. Bye.

PROF KING: If you could please state your names, the organisation that you're representing, and any other comments you would like to make for the transcript?

MS LETHLEAN: Hi, Vanessa Lethlean, Managing Solicitor at the Top End Women's Legal Service.

MS WEATHERBY-FELL: And Caitlin Weatherby-Fell, the Senior Solicitor at the Top End Women's Legal Service.

MS LETHLEAN: We've just got a really brief opening.

MS ABRAMSON: If you'd be kind enough to speak up a little bit? The microphones are not for amplification; they're just for the transcript.

MS LETHLEAN: Okay.

MS ABRAMSON: Thank you.

MS LETHLEAN: Okay, so the Northern Territory has the highest incarceration rates in Australia, for both women and men. And in the Northern Territory, almost half are convicted of a violent act, which is the connector with DV.

Our service, the Top End Women's Legal Service, has been providing services to women in the greater Darwin region for over 20 years; for the last 10 years, we are the only family and civil law provider of legal advice to incarcerated women in Darwin. We currently attend Darwin Correctional Centre every third week, and we have over a hundred open legal matters. In the last five years, service demand has increased by 500 per cent, and so have our KPIs, but funding remains as it was; so there's an increasing service gap.

We welcome and endorse the draft report, the focus, the findings, and the proposed draft recommendations in relation to the mental health needs of women who are incarcerated. Unfortunately, the number of women incarcerated in the Northern Territory has, in fact, increased by 440 per cent between 2004 to 2014; and a large part of that is for four reasons:

Women have multiple, unaddressed, pre-existing vulnerabilities which are compounded by the incarceration. And women present with really high-level complex trauma, and they do require therapeutic service provision, to both address recidivism, but also the foundational issues, but there is none available.

There is assistance focus on criminal acts and criminalisation, and there's very little consideration given to holistic responses, and very little consideration given to some of those foundational issues, which of course are family and similar matters.

And also, the women who are incarcerated really are devalued and invisible to the policy systems on the structural level. So a really clear example of that is when they built the prison in Darwin. The women's sector is completely surrounded by men who are incarcerated, and immediately next to high-risk serious male offenders. And that's a failure, and it's got really substantive implications.

So from our perspective, and the research shows, domestic family violence is a foundational issue for a broad range of women's offending, and it's very significant in relation to the increasing incarceration rates.

In 2019, the number one non-legal ask for women who are incarcerated in Darwin is access to specialist domestic family violence, trauma-informed, culturally appropriate counsellor, and unfortunately that's not available at all, and our service has worked for years to try and bring that to be.

So it's very clear for women who are incarcerated in Darwin that access to such counselling is pivotal, and it's a really crucial step to breaking both the cycle of incarceration and for domestic family violence, which are really foundational to their health and wellbeing in therapeutic hands. The ongoing service gap really is a lost opportunity to reduce both the contact and the costs associated with the criminal justice system, and the impacts for community, for family, and the individuals.

And just by way of summary, the Northern Territory Coroner has described domestic violence as a contagion, and the Ombudsman, a decade ago, indicated that women constitute a small but growing part of the NT prisoner population. And it really presents an opportunity here to get things right, and from our perspective, a positive way forward on both fronts, really, is to make provision for a specialist domestic family violence. And I really don't want to be here for another decade, with this issue unaddressed.

So that's our opening comments and of course we've made two submissions.

MS ABRAMSON: Look, thank you very much for that. I've got some questions I did want to ask you, but I suppose on the domestic violence issue, it's not that the Commission didn't understand that it was an issue; we're certainly looking through the mental health lens. So perhaps some commentary on sort of social determinants of health, but because we're a mental health inquiry, we didn't go for that, and we've had other things, especially with the Victorian Royal Commission into domestic violence who've said well, you haven't

really dealt with it. And that was just because he - it was such a broad inquiry. But we understood the issue and I understand your submission.

So I wanted to ask you, we've got a number of recommendations about diversion and I'm really interested because it all operates differently depending on the jurisdiction that you're in, so what's the experience in the (indistinct) of diversion programs? Are none of your - your clients actually have the ability to refer to a diversion program?

MS LETHLEAN: I guess the comment I would make is that the Northern Territory has an Aboriginal Justice Agreement.

MS ABRAMSON: Yes.

MS WEATHERBY-FELL: And a draft Aboriginal Justice Agreement.

MS LETHLEAN: Yes. And underneath that lies a pilot project that's currently operating in Alice Springs that includes diversion, so housing and some additional service provision. That's great because we don't have a criminal legal practice; we wouldn't be the right people to comment on the availability of diversion.

So our point of contact for women who are incarcerated is at that point. We run quite a large practice and we can see them on other occasions in an unrelated way. But can I just comment on this issue to do with domestic violence.

In our experience a large number of our clients (indistinct) focus on the prison, have mental health issues, whether it's post-traumatic stress disorder, whether it's depression, whether it's drug and alcohol which is (indistinct) because they're not coping with (indistinct) that day to day reality because of a whole range of trauma that's occurred. And so whilst the presenter statistically might be an indicia of domestic family violence if you explore it, it's in fact a really high level complex psychological issue that does warrant and should receive an appropriate response.

These are women who are predominantly mothers, so we're talking about children where there would have been exposure. There are also quite often significant within the cultural context which means that they're holders of a whole range of responsibility and knowledge. The impact of the removal is quite severe. And it's part of that vortex and part of that critical mass and it's a fantastic opportunity while the numbers are still low, comparatively, to go in and do what you're talking about. Some really early work prior to incarceration and also to offer it in incarceration. Absolutely there. And absolutely possible.

MS ABRAMSON: Yes, I think, one of the other things that we've observed, our (indistinct words) I suppose is because we're looking right across Australia and they're a different system but we also observed that there weren't standards for the type of support that you should have for mental health in the prison system or we couldn't find one. And yet in the community, I'm not saying we (indistinct) them, but at least there was a bench bar. These

were the things but we couldn't find them in the prison system and I'm assuming that would be the case in the territory as well.

MS WEATHERBY-FELL: Very much so.

MS LETHLEAN: That's absolutely the case and the territory doesn't fair as well as some other jurisdictions in terms of what is actually available. But from our perspective, we would say there was a standard. And the standard across all of Australia is that access for people who are incarcerated needs to be the same as access for people who are incarcerated needs to be the same as access for people who can't and that's a stumbling block. We've definitely done third party representative complaints where we're quite proactive on this issue because of the impact and the potential benefits that can be achieved and so that standard which is universal across Australia is not being afforded from our point of view to women and clearly the men, but that's not (indistinct words) who are in the Northern Territory.

There's a range of ways to address it, we appreciate that Corrections doesn't have a budget for that but the Commonwealth can certainly look at the regulations for Medicare rebates because those services are not available on a Medicare rebate. So in the Northern Territory, we could have, as we are aware of, a culturally appropriate trauma informed indigenous specialist who would go in on a Medicare rebate basis but can't and the reality is that the services that exist in Darwin for domestic family violence don't have the capacity to attend.

MS ABRAMSON: On the capacity point, I think it was before you joined us, but there were very different workforce issues, so even in the ideal world if the funding were available presumably we would still have workforce issues. So I'm interested in your views on that.

MS LETHLEAN: My backdrop comment would be if you want to get bang for your buck, you go to the specialist and you locate them appropriately, so this mainstreaming approach which is occurring is not the best outcome for clients because funding that's dropped its services who don't have that history, who have to recruit, who have to make support, there are appropriate NGO's in Darwin where if the money was made available, they hold that expertise, they hold the support and the ability to network, to facilitate, appear in a discussion. And that's where we would say the money is best spent or best located.

MS ABRAMSON: So you're - in your model, even (indistinct words) relevant to those organisations, (indistinct) for Medicare to (indistinct words) the money. That would mean that they could see the support workers and peer workers into the prison system for work (indistinct words) incarcerated people.

PROF KING: Sorry. Just how much though - I wonder how much also needs to be - from the indigenous population needs to be in community. So I guess from two perspectives, one is that since (indistinct words) individuals have got on the justice system radar, since (indistinct words) the interventions really should have been from the technical perspective before (indistinct). And secondly, that you can have the best possible treatment in a prison

system but if the woman is going back to a dysfunctional relationship which involves domestic violence, she's simply going to be traumatised. You know, we try to put a band aid on the wrong part of the cycle in metaphors, but views on that. I mean, you're seeing a particular half of what I see as being a much longer spectrum (indistinct words).

MS WEATHERBY-FELL: Well, that's (indistinct words) building intervention with people much younger so they can make healthier decisions and they have a healthier path forward, is absolutely in that foundation of - but the reality is that these issues are underlying incarceration and there is nothing available at that point. (Indistinct) contact points represent an opportunity and it may not be the best, but it would be - or the earliest point, but it may well have been really important for that person to address what's part of their day to day reality. And I understand your question in terms of indigenous women, as also wanting to choose (indistinct words).

PROF KING: Of course (indistinct words). Yes.

MS WEATHERBY-FELL: I think the issue on community is extremely complex in terms of again, critical mass on community. My - I guess my initial comment (indistinct words) you don't have connectivity, you aren't structured appropriately with the appropriate workforce, again, you just don't (indistinct) the outcomes that you (indistinct words) money. And it means you need specialists, you need culturally safe, competent services that go in - and not generalist services that don't hold that.

Services really that are able to develop those key relationships that are necessary to facilitate that ongoing kind of learning and support system that, you're right, is needed across the whole spectrum of that cycle, not just at this point where we're talking about now where someone has already entered into the justice system, has been incarcerated for X period of time. But as the report noted, this is a great opportunity, it's the gateway for these women to receive that support and for our service we'll often see clients who were able to assist with a number of matters which have contributed to her incarceration so that when she is released, she's in a much better position than she was prior to hopefully addressing that issue of (indistinct words).

PROF KING: Can I pause there now to ask - and apologies because I put two questions together and so (indistinct words) making a (indistinct words) Aboriginal and (indistinct words) so my apologies. I was actually referring to the (indistinct words) survey (indistinct words) domestic violence and trauma counselling. And my understanding, and I'm not (indistinct words) but my understanding is that women who for example are suffering from domestic violence, even if they still receive good trauma therapeutic service in, say, prison situation, if they then go back to the situation of domestic violence, it's simply going to be traumatised with not actually solving the issue and is that your understanding? And understand that you know with some of these at least we get a contact point, at least we get something better than nothing, but it's a bit like, you know, if I can do a workplace analogy, someone slips over on an oil slick or breaks their leg, we send them to hospital, fix the leg up, we send them back to the factory with the oil slick floor there again, we shouldn't be surprised when they come back to the hospital with a broken leg again. In some ways, do

we risk that happening to women subject to domestic violence where because we're not actually addressing the underlying problem of domestic violence in the community – in the broader community, to make it clear, we're not solving the problem. We're just simply setting up the cycle again.

MS WEATHERBY-FELL: It's a really important part of the picture, though. I accept what you're saying, that within the broader community, gendered violence starts somewhere and that needs to be addressed, both with young people, older people (indistinct) in the community. But part of our response about a need for a counsellor, a specialist and a family violence counsellor at the prison is that that counsellor needs to be external, okay, for therapeutic reasons, but also as a potential point of contact post-release, and if that connect is solid – and we certainly see clients who have said, 'I've seen this counsellor, that connector was good to me', and they'll return. So there's a period of time where if there's a good connector made, that can continue post-release, and no, it won't perfect if people are returning to a remote community and I think that's an issue that we don't claim expertise on other than to say fly in, fly out.

MS ABRAMSON: Can I ask you, it may not be in your area, so that's – I'll ask you some other things, but mental health tribunals, we have – we were quite surprised – well, not surprised. We knew that legal funding was constrained – legal aid funding – but it seemed to us that the most vulnerable of people were not necessarily getting supported by the legal or other support services in appearing before mental health tribunals, and the evidence was quite stark that when people did have representation of either form, that actually, compulsory treatment orders were much less likely to be issued. So do you have some experience in that area?

MS WEATHERBY-FELL: It's not a practice area that we hold strength in, so I'd prefer not to comment on that. I think you need to talk with someone who's consistently there, who has a high, you know, percentage of their workload. So the funding in Darwin for those services is shared by the Legal Aid Commission as well as NAJA, the Aboriginal Justice Agency. That's in Darwin, at the very least.

MS ABRAMSON: Could I ask you about the legal aid funding, because you made the point that the national legal aid funding is only available for criminal matters. But there is some funding, isn't there, made available in Family and Civil where it's so tiny it's not noticeable?

MS WEATHERBY-FELL: The comment there really is about – the Commonwealth has a formula which is relevant for the assessment and that weighting only goes for criminal law matters, and you'd have to talk with the Commonwealth about how significant that is. But from our service's perspective, it's again one of those four factors where the priority is given to the criminal charges, the criminal process, and I'm unclear why there is no weighting within civil and family law matters for women who are incarcerated.

MS ABRAMSON: Have you got any?

PROF KING: No, I'm good. Thank you very much.

MS ABRAMSON: Thank you.

PROF KING: That's been really – and thank you for this.

MS WEATHERBY-FELL: Have a good day. Enjoy Darwin.

MS ABRAMSON: Yes.

ADJOURNED

[10.34 am]

RESUMED

[10.37 am]

PROF KING: Now, just for your information, we are on transcript because it is a public hearing so if I could just ask if you could state your name, any affiliation that you have for the purposes of the hearing and the transcript, and any opening comments that you would like to make.

MS PILTZ: Good morning to you, both. I'm Hristina Piltz and I'm appearing today in a personal capacity, I'm not representing or speaking on behalf of any organisation, however in the interests of transparency and disclosure I should note that I have spent several years working for a large global pharmaceutical company and that professional experience very much is gone to aiding my submissions and the remarks I'm going to be making today.

I've also been a carer for a family member who was preventatively medication for a mental illness at a very young age. I'm really grateful for this opportunity. I've contributed to some other Productivity Commission reviews and Senate inquiries and in that time I don't think I was in such a large community response driven submission process so it's pretty clear you've taken on something that's of great significance to the Australian community. In terms of - sorry, are you there?

PROF KING: Yes.

MS ABRAMSON: Yes.

PROF KING: We're listening, yes.

MS ABRAMSON: We're listening.

MS PILTZ: Okay, so I will just I guess read through my opening statement. As I've outlined in my submission, my key concerns are around the early childhood recommendations in a later report. I'm in complete agreement with the conclusions that

early intervention is absolutely essential when it comes to mental health and it is registered as being our resources. But intervention has to be evidence based and in my professional opinion it would be ignorant and dangerous to enact the early childhood recommendations prior to some much needed legislative changes to ensure that children are kept safe.

And what I'm particularly speaking about is demonstrated practice of off label prescribing. I may just explain what I mean by off label prescribing with a non-mental health example. So off label prescribing is when a doctor prescribes you a medicine for a condition that the Australian regulator, the TGA, hasn't deemed it to be safe or effective before. So let's say, for instance, you're pregnant, which is an example I recently went through with my friend because it was what had happened to her, and you feel nauseous and you go to see your obstetrician and he prescribes you Zofran.

Now Zofran is registered on the ARTG, that is the drug company has provided the TGA with safety and efficacy data but the safety and efficacy data demonstrated that it was safe and effective for use in cancer patients that were experiencing nausea from chemotherapy. So if your doctor prescribed, you were pregnant when you took Zofran, for your nausea, we would say that it's an off label prescription.

PROF KING: Yes.

MS PILTZ: So, yes. Now why would a doctor prescribe such a product to a pregnant woman, you may ask, there's not a lot that make sense and is somewhat reckless, I certainly don't think it's because the doctor wished the mum or the baby any harm, my industry experience would suggest that it may have something to do with a lack of disclosure around how industry engages with the academic community and the professional prescribing bodies that often write the clinical guidelines that guide clinical prescribing practices.

Now interestingly for that example that company was sued for \$3b and they paid that fine but based on my friend's experience she was prescribed that product three weeks ago in her first trimester when TGA guidelines actually state very clearly that it causes birth defects and should not be prescribed in a woman's first trimester. So you could kind of go, well, hang on, the company is fined how could doctors still be prescribing it?

And I think that comes down to the fact that once these prescribing practices are in place for physicians it takes quite a bit of work to re-educate them. And I don't think it's in anyone's commercial interest to do so. And it's not really placed on any government regulator to do so. So while there's retributive justice I don't think we've had - we don't have any mechanisms for restorative justice when these kind of things take place.

Now, so that was - yes, my concern is that the commission may not be aware of these regulatory parameters and therefore how they may interrelate with some of the recommendations you've made. My concern is that the draft recommendations, particularly around the social wellbeing early childhood ones and some of the workforce ones may actually promote the practice of off label prescribing of psychiatric drugs amongst young children. Now that's not to say that that will happen but there very much is the potential

for that.

Now not only does such a practice have the potential to cause harm to these children and families but administering treatments which fail to have an evidence base for them is also wasteful to the Australian taxpayer dollars, the PBS already makes up a significant portion of the health budget, and it's only growing, and I think it's vital that resources are expended on evidence base therapeutic interventions. And then there's the consideration of what impact will this have on national productivity.

Yes, early intervention has the potential to enhance national GDP but not all early interventions are equal, access to interventions that lack an evidence base may actually do more harm to our national GDP. I think in my submission I also made reference to some figures that are highlighted in the draft report around the perceived trajectory profile of mental illness and that is that it begins early in life and tends to decline with age. But I think that's really important to keep in mind because it is very much in the commercial interest of industry to demonstrate that these products are safe and effective for use in infants, children, and adolescents.

And I think it would be naive to assume that just because they haven't been demonstrated to date that industry hasn't tried. So, yes, I think it's - I know some of the push backs that people may say well it's actually really hard to run these trials amongst the infant population and children, it's unethical, but I would sort of question well how much more unethical is it to therefore be giving it to them outside of trial circumstances without the evidence base. And I have seen some statistics which suggest that off label prescribing of these products is something that does happen in our country.

Yes, now I've covered a few more issues and provided a lot more detail about the concerns
- - -

PROF KING: In your submissions?

MS PILTZ: In my submissions. But I guess what I'm trying to stress is that good intentions are not a substitute for good evidence. But please don't take my word, I encourage you to talk to experts like Fiona Godley at the (indistinct) and she is across (indistinct) more than I am, and if you need someone locally I suggest Lisa Bero, she's recently moved to the University of Sydney from the University of California I think, and she's a global authority on industry influence in science. And she's a former Cochrane co-chair. Consult with these experts and I guess to understand a bit more about current regulatory parameters and how they make them and the potential they may have to actually enhance the rate of off label prescribing of these medications in Australia.

PROF KING: Okay, thank you for that. Your submission, and thank you, very much, for your submission, I certainly personally found it very valuable.

MS PILTZ: I'm glad you read it. And I can't tell you what it really says for me.

PROF KING: No, no, I believe you.

MS ABRAMSON: Hristina, we've absolutely both read it, although I did notice that a number of things are related to Stephen's previous life.

PROF KING: Related to Dr King in there.

MS PILTZ: His background, and - - -

MS ABRAMSON: No, we've both read it and it was a very well put together submission and it was easy to follow so thank you for that.

PROF KING: So it does tie very nicely into, if I can call it, a series of issues that have come relating to medicines in this inquiry. So as you know off label prescribing - well, sorry, I'll start at the other end. There is the issue of testing the randomised control trials the way that they're being conducted, and you would know probably better than I do that there have been issues raised about the efficacy of the approach used for randomised control trials, for example. But failed trials just disappear without note and successful trials obviously then get reported.

MS PILTZ: Yes.

PROF KING: Which means that overall if they're the same trialling for one drug it means that statistically the randomised control trials they did before that is not statistically valid. So there are all these statistical issues behind and they have been very well documented mainly in the psychological control trial space, as I understand, the inability to reproduce evidence.

MS PILTZ: Yes.

PROF KING: So I guess that's an underlying issue which is probably beyond this inquiry. But then at the next stage we are well aware of the off label prescribing that occurs for drugs that are related to mental health issues, for example, I think we get second highest in the world in terms of the percentage of population prescribing of antidepressants.

MS PILTZ: Yes.

PROF KING: Most of - well, no, I won't say most because I'm not because I'm not - 50 per cent, a substantive portion of which is off label. So generally, you know, and that's adults as well as children, so we're aware of off label prescribing being an issue. We're also aware of, you know, and this also reflects back on the pharmacy inquiry, GPs as well as specialists who simply can't keep up, if I can put it that way, with the latest research and the latest evidence on the medications that they may be prescribing and the risk that that creates to the community.

So we're aware of all of those. And I thought your submission in particular resonated as a

potential way that - I would like your feedback on whether we should be thinking this way, which is should we be thinking about recommendations that limit off label prescribing if not for a general population should they be limited for, for example, adolescents, or children under 12, should we be thinking about recommending to government prescriptions of off label prescribing?

MS PILTZ: I would say absolutely yes. I would say that if we were in America if you did that there would be a huge push back and I'd say yes do it but I don't think you would have any chance of doing it. I think you have a chance of doing it here in Australia because - I don't know how to put this without saying it too critically - there are lots of shootings in America that are happening and we only needed one to be able to as a population look at that and say actually that's not okay. But there are reasons why that can't be the case in America.

I think once there are enough people who are aware of the practice of off label prescribing of these medicines to adolescents when we don't have evidence of their effectiveness I think the most sensible course of action is to say, well, no, no, this isn't a safe practice for our children. So, yes, absolutely, and I think there's more chance of that getting through in Australia than there is in other markets. And I think it will send a really strong signal to other countries. We have a really - our PBA is looked at by other nations around the world and what we do in that regard people look to us and so I think that would be incredibly innovative in Australia to push something like that forward.

PROF KING: Christina, thank you, very much for that.

MS PILTZ: Yes. I don't know if I've said too much.

PROF KING: No, no.

MS ABRAMSON: It's okay, it's all been very helpful. Like I have to confess, I left some of the questioning to my colleague, Dr King, because I know with his pharmacy review background he was particularly interested.

MS PILTZ: Yes. I've actually - just so you're aware, I have contacted industry colleagues and I let them - the company that I used to work for, I contacted the head of their public affairs department before I made the submission because I have so much faith in the integrity and character of the people that I work with and I knew that I could do that in good faith and not get strong push backs because they're decent people and we always worked for making sure there was appropriate access to medicines, and the only feedback I got was good on you, that would have been tough to put together given your background so good on you, it's the right thing to do. So that's why I have faith in the fact that this is the right thing and we have an opportunity to do it here in Australia a lot more free-er than others do in other markets and I see no reason not to do it.

MS ABRAMSON: Thank you, very much.

PROF KING: Thanks, Christina.

MS PILTZ: Thank you.

PROF KING: Tea break, coffee break. Let's take a bit of a break, we're running a little bit late so if we can start again - it's not that late, if we can start again at 11.15 that would be fantastic.

ADJOURNED

[10.52 am]

RESUMED

[11.16 am]

MR SMITH: Hello, Stephen. Warwick Smith here.

PROF KING: Hello, Warwick. How are you?

MR SMITH: Good, thank you.

PROF KING: Now you've got myself and Julie Abramson here and - all ready to go with the transcript? All good? Yes. Now, so we are on transcript, because it's a public hearing, so if I could ask you, just first, Warwick, just so state your name, any organisation you're representing, if any, and any opening comments that you'd like to make. Warwick, are you there?

MR SMITH: Can you hear me?

MS ABRAMSON: Yes.

PROF KING: Now we can hear you, sorry.

MR SMITH: Okay. I think the microphone just dropped off, so I apologise for that.

PROF KING: No, no.

MR SMITH: Look, good morning. My name is Warwick Smith and I'm presently in Perth and I made a personal statement to the Productivity Commission. Now, can I just give a bit of a background and firstly start by acknowledging the lands we live on today, the Whadjuk people, the Noongar nation in Perth, and the Larrakia people, the traditional owners of the Darwin region. I pay my respect to elders past and present and the emerging leaders that we need for the future.

A bit about myself; I've been privileged to be a clinician, Allied Health, and have experience in working in paediatric, child, adolescent, youth, adult, older adult mental

health services. I've worked in in-patient and community settings and for both the Department of Health in Western Australia and for the community sector.

But I've mainly worked in leadership positions in Western Australia for the last 30 years. I was the Director of Richmond Fellowship in the late 1980s and have been a senior policy officer in the Department of Health and have been Clinical Director at CAMHS, Director and Operations Manager at PaRK Mental Health and I'm presently the Director of Youth Mental Health, Department of Health in Western Australia.

I've been a surveyor, now assessor, with the Australian Council of Healthcare Standards and I've been privileged to see Mental Healthy Services across Australia from 2007 to present in that capacity. I've had a passion for effective clinical governance, particularly how services use the voice of the consumer to improve services, the importance of integrated systems and the benefits of a focus on high quality service provision.

If it was okay, Stephen, from your end, I'd like to give a bit of the background to our contribution to the Productivity Commission to date and then some personal reflection, if that's okay with you?

PROF KING: Yes, although I would point out we have read your submission.

MR SMITH: Yes, okay. That's fine. And so I think - just going through, I think that Youth Mental Health made a number of submissions in April 2019 and also January 2020.

PROF KING: Yes.

MR SMITH: And provided a number of appendices in there and the one that we particularly chose were the reports for Mental Health Advisory Council for Western Australia, the submissions that we made last year about accommodation performance, knowing that housing is so important for our people with mental illness and I think when we reviewed your October draft report, we tried to provide some answers to the questions that you had in your draft report, which was very, very comprehensive.

The appendices that we gave were, I think, an article that we had published about the making of one of our public health services trying to be bicultural. They've got a really strong record of providing services to Aboriginal young people.

The Youth Wraparound was an article that we provided contemporary mental health services to a 15 year old child who had two thirds of their life in institutional care throughout prior to that and we made significant reforms in providing community services. The savings were significant and now that young person is going to TAFE, lives in a house, has friends and has a pet.

So I think they're some of the appendices that we provided to you. I think this morning I was just going to focus on a number of areas that were provided in the previous information and the first one was about integrated placement and support.

Now, I know that the Productivity Commission is really looking at the meaningful role that people can play in the future. I'm IPS trained. I went to Dartmouth in the USA and I visited a IPS psych in Lanchester and I've provided some information in my personal submissions.

And when I went to Manchester, which was in the USA - the population is about 170,000 people - there was ten IPS workers employed. What they found is that about 80 to 90 per cent of people with significant mental illness would like to be employed and they had significant outcomes. What they were trending about 85 per cent of people would get employment with the IPS model.

And when I spoke to your staff, who rang me back after I submitted my reply, I think it was really underestimated, the number of people that can benefit from IPS in Australia, who could be assisted into meaningful employment and meaningful education.

Since your staff member rang, we did an audit of one of our acute mental health services and we took away the number of young people who were employed. We actually found that for those that could benefit from supported employment IPS or supported education, it was 100 per cent of the remainder.

So we could actually take people with quite significant mental illness and support them into education and employment far, far better than what we have been doing presently in Australia, I think. And I think that was the comments I made in the submission. Professor Geoff Waghorn has reviewed the material I provided to you and he agreed with the information that was provided.

MS ABRAMSON: I think Professor Waghorn might have appeared in Perth at our hearings.

MR SMITH: I think it might have been Brisbane because actually - - -

MS ABRAMSON: Brisbane, yes, yes.

PROF KING: Brisbane. Yes.

MR SMITH: Yes, yes. Geoff said he made submissions, I think it was in Brisbane, and I have a lot of esteem for Geoff. He's gone to work in that area, so I had him actually review my data before I provided it to you.

The other one I think is the appendix in my letter and I think it's a personal reflection that even though that we were trying to mainstream with health services since the 1992 plan, it has not always been a good process for mental health services and I think there are many occasions where the budget for mental health services has actually been taken away.

You know, absolutely - there's a number of examples I've provided in the appendix where, you know, like 26 mental health services are told their budget will be quarantined and then 26 of them overheads are put on board. And we had a situation a few years ago in Perth where we'd reported that to the Mental Health Commissioner and it was trying to take away money to prop up mainstream health services and I think it's a significant issue in a number of jurisdictions, that they report that the money that has been dedicated to mental health is not always kept there and is often siphoned off.

And when we were trying to review, like we looked at the structure that you're looking at for the purchasing - there's a report by Murray Wright 2017 Chief Psychiatrist. I think he's made a number of really sound recommendations for good governance of mental health, particularly the recommendation three about accountability in governance, where he said that the Director of Mental Health should be a member of the district or network senior executive and report to the chief executive. And that may be some way, we hope, to look at some of the difficulties that mental health has had in trying to move ahead.

The other one to flag is the integrated systems of care. When I looked at the really exemplar services in Australia, these were lower North Shore in Sydney in the late 1980s and 1990s, Thalia and Warrnambool in Victoria, PaRK Mental Health WA and Youth Mental Health.

They've all operated in a continuum of care, from the schools or the GP through to the public sector, they've all seen that they were trying to provide an integrated system of care to support young people and families, but also support the GPs to provide better managed care and I think they've also focused on quality.

In Canada, there's a service called Foundry and it's worth reviewing. And they gave a presentation to an international youth mental health conference in Brisbane last year and Foundry becomes the front door. You know, young people go there; they're youth friendly, they're really appropriate.

But I think what is really important in Foundry is that there are 130 agencies that have signed up to the system of care through an MOU to ensure that young people and their families are assisted to the right service. And the integrated system includes cross-sector training, research and accreditation and that, I think, would be really worthwhile exploring for Australia.

Headspace were there, the national headspace office and they would have liked to have achieved the Foundry system of care approach in Australia, but they didn't do it; they weren't able to do that in Australia. And when I look at the services that get good feedback from GPs and schools, I think they really approach it in a systems of care approach.

PROF KING: Sorry, did - no, it's an unfair question. I was going to ask why did headspace think they couldn't achieve that in Australia, but that is really - that's a question we'll need for headspace, so apologies if I interrupted you.

MR SMITH: Yes, yes. No, I think it's - like, it's a really important questions. And it was like, at the forum that was in the International Youth Mental Health Conference in Brisbane and I chaired two headspace consortiums in WA and I've been involved in a number, trying to get them up and running, and I can tell you that that would have been, I think even now, a good way to continue.

PROF KING: So, sorry Warwick, because I interrupted, I may as well continue the interruption and then let you continue; so the Foundry model - and it's not one I'm familiar with, although there might be people on the team who are familiar with it - is it sort of a physical model where it then provides the access to services, is it a virtual doorway? Yes, a bit more detail?

MR SMITH: It's a physical place, but it's also virtual and people can contact them by phone and by, you know, social media, but I think the approach is that if they can deal with the front door end, but they've also got a number of 126 agencies beneath it that aren't all co-located and the model is much more about bringing the person and the family to the right place.

And I think - I don't know if your team are aware of the Toronto Navigation Project by Dr Anthony Levitt; he's been in Western Australia and Australia a number of times and they have a team of carers and a consultant psychiatrist.

Similar model; they're trying to link the person and the family to the right service and I think those are missing in Australian jurisdictions, where we focus on the organisation, to the exclusion of how do you help the service apply for young persons, the families, the adults to the right service model.

PROF KING: Yes. Which is different than a headspace approach, which is - and I don't want to downplay it, but I mean, it's more the young person goes in the front door and there are particular services there, but less of a linkage back into the broader community.

MR SMITH: Yes.

PROF KING: Yes, but it's different than a headspace approach, which is - and I don't want to downplay it, but I mean, it's more the young person goes in the front door and there are particular services there but less of a linkage back into broader community. At least, that's my impression. Your (indistinct), so.

MR SMITH: I'm the independent chair of the - two of the consortiums.

PROF KING: Yes.

MR SMITH: And I would absolutely agree with you, the focus is on the building as opposed to the (indistinct) assisted care model.

PROF KING: Sorry, Warwick, I interrupted you. So please, get - continue on.

MR SMITH: No, the areas – I’ve only got a few more, by the way, Stephen, so I think that was okay, and if you want to ask questions that’s fine. I think the other one that I don’t think comes strongly enough in your report is the development of people, and I think when you look at the (indistinct) services across Australia, the areas that they’ve done very, very well in is leadership development, and I think it’s more than just budget. It’s about how can leadership be thinking for the future, you know, models like John Kotter, really well. But I think the leadership for the future are going to be the leaders who can work across different domains, not just focus on the service that they’re running. I think they’re more management. But I think that the leadership that we really need to develop for the future is how to have leaders that integrate service delivery. So you’ve got Department of Education, you’ve got Housing, you’ve got Mental Health. All the social factors that we need and know make a difference. I think – the leadership development, I think, needs to be strengthened in the children’s mental health space, particularly that cross-sector approach, I think, was really important and really, how to emphasise the quality for young people, and the other one is the development of staff.

I think that is the area that in my experience, in 30 years – if you’re really investing your staff in contemporary roles that are client-focused, you’ll really get wonderful results. Probably a couple of years ago, I was awarded the co-winner of the Exceptional Contributions to Mental Health Service in Australia and New Zealand, about 2000 and, I think, 18, and funnily enough, when I think about my career, the things I tapped into the most is, I was in – before I started in mental health, I was actually on the national team for white-water canoeing. I went to world championships around the world and I got coached by a – one of the best coaches in the world, and then I became a coach and so I’ve become a coach at state and national, and my athletes have got medals at Olympics and at white-water championships, and I think, for me, bringing that preparatory development for our staff, whether they’re peer support or professional, I think has made a difference in the services I’ve managed, and so it’s past in use. It has extraordinary results from clients and consumers and they’ve won many, many awards, and I think they’ve focused on really good service elements that are important, and sometimes I would tell my clinicians, you know, provide a service as if it’s your mother, your father, your grandfather, your brother, your sister, your son, your daughter, and so they really understood that they were out there every day to provide a high quality service to people who had come to see them, and I think that could be strengthened in the report.

The last part, I think, is our lack of implementation, and Australia is world-class in having wonderful planned mental health. But we do not do well in the implementation of the plans or consistently resource the services that are needed by people that are experiencing mental health distress or illness. My reflections were that the national plan in the early ’90s – 1990s achieved reforms across Australia. As (indistinct) Australia’s state level, the reform by (indistinct) purists, in 1996 through the Liberal government and then by Tim McKinney later in 2004, achieved reform in mental health. You could feel it. Staff, consumers, carers could see the reform that was being done and they could actually see the positive changes. What the consumers, carers and staff experiencing - about the reform in – principally in Western Australia is that it’s lacking. We had a wonderful mental health plan for 2015 to

2025 which is an excellent plan. The plan has been well-researched and consulted widely. It has many important actions for children, adolescents and young people, 2015 to 2025, that would significantly improve the health and wellbeing of children, young people, their families and our communities.

Unfortunately, it's close to five years since Mental Health Change was launched. Very few of the actions have been implemented for children, adolescents and young people. The majority of actions have not had the work undertaken to progress, and that was - the Auditor General of Western Australia identified the lack of implementation plan in Western Australia and I think we have to really be aware that that is a factor, is - how you're going to plan that implementation is really, really important.

PROF KING: Can I ask you - just related to that – you brought the Auditor General up and I note in your submission that as I understand your view of the two options, the rebuild or the renovate model, that the rebuild is the preferred model. It doesn't take a genius to work out that we got the idea from the WA Mental Health Commission model and that was our starting point, but the Auditor General's recent report – I think it was December, it might have been – into the WA Mental Health Commission and how it was progressing in terms of rebalancing services was very negative, or at least my reading of it was very negative. It basically said, well, you know, it was meant to rebalance towards community services. It's been singularly ineffective at doing that. Any thought on that? Because you suggest you prefer or you state you prefer the rebuild model, but we're wondering why, in a sense, what we expected to see in WA hasn't occurred, and is that due to implementation? What's gone wrong?

MR SMITH: My personal reflections would be that we've had a state – the previous government launched the mental health plan and we had a period of time in WA with a (indistinct). But I think at a government level, mental health does not have an agenda that is given significance. If we've created a (indistinct), we've put \$1.4b into the Optus Stadium for football. We've had a – Graylands Hospital has been - from the 1992 mental health plan, there've been plans to move it to a mainstream health services hospital, and they still haven't done it. So probably, they have not invested the money to move Graylands into a contemporary service and I think that is reflective of how the state government presently is viewing mental health. They haven't done it, and so what you have is a lack of action at a state government level and the mental health condition is not seen as a beleaguered area to reform. All the actions and - for children, adolescents and young people haven't been enacted. Absolutely have not been enacted. So what the young people (indistinct) services that were really awesome have not been provided, and particularly in areas throughout Western Australia where eating disorders, young people from a friendly background – and we've also got a crisis and assessment team that's been planned for Perth – none of these really important areas have been implemented. So what you have is the number of plans abounding for about 15 to 20 years and a lack of implementation.

PROF KING: All right. Thank you very much for that, Warwick. Did you have any - -
-

MS ABRAMSON: No, no questions, thank you.

PROF KING: No, all right. Thank you very much for your input here today.

MR SMITH: Could I make one more statement, by the way?

PROF KING: Yes, please.

MR SMITH: Okay. I think – to be honest, I think the other one when it comes to productivity for Australia is about the blueprint mental health reform needs to be longer. I think in my personal statement I said it needs to be 2020 to 2070. I think because the issues are intergenerational, if we only stick to three- to four-year time periods, we won't achieve it and I think the true approach is going to be the true leadership. I think the productivity report has been really fantastic in the work that you've done and you should have thanks to your team as well for the work that they've done, but I think it's going to take the federal and state and local council true leadership to bring that together and implement the recommendations of your report in a meaningful way, and I think that would really make a significant improvement to mental health across our nation. So I just wanted to say thank you for the work that you're doing and I really look forward to the implementation of the productivity report. So thank you very much.

MS ABRAMSON: Thank you.

PROF KING: Thank you, Warwick.

PROF SHEFFIELD: Hello?

PROF KING: Hi, is that Les?

PROF SHEFFIELD: Yes, this is Les, and I've got Allan and Sam Mostafa with me.

PROF KING: Excellent. And at this end you've got Stephen King and Julie Abramson from the Productivity Commission. So, this is a public hearing so you're being recorded on transcript. So if you wouldn't mind after just introducing people, if you wouldn't mind re-introducing your team, your organisation, state your organisation and any opening comments that you would like to make, please.

MR ALLAN SHEFFIELD: Yes, thank you. And can you hear me okay?

MS ABRAMSON: Yes.

PROF KING: We can hear you perfectly, yes.

PROF SHEFFIELD: So my name is Professor Len Sheffield, I'm a clinical geneticist. I have with me my son, Allan Sheffield, who is one of the directors of our business. I also have our clinical director, Mr Sam Mostafa, who is a (indistinct).

PROF KING: Excellent.

PROF SHEFFIELD: And our company is myDNA. We're a genetic testing company and we specifically started and one of the main things we do is genetic testing for medication, to match people's genes up with their medications.

PROF KING: All right.

PROF SHEFFIELD: So I'll start off with a brief introduction. You've heard I'm a clinical geneticist. I've been involved from the very beginning with my lecture Genetic Care, and I've helped introduce several new tests to the drug market and to the health area. I've worked most of my career in the government service, then joined the clinical and genetic service. And for the last 12 years I've been working for my company, myDNA, which was really formed because I found this new area that wasn't being provided by the (indistinct), and we've done and we continue to provide (indistinct). (Indistinct words) have become much more into the mainstream and I'll tell you what (indistinct), and is now available through all the major pathology. But the test matches people's genes with their medication. And so we've provided in our application a solution to help people who have depression because one of the major treatments of depression is medication. The problem within the medication is that it's got quite a high rate in which the medication is not the right one for the person and it doesn't work. That's up to 50 per cent. And then quite a bit of guesswork in trying to get the next best answer. People need to be on the first one for several weeks and then they will go on to another one that takes four. There is no, except for our tests, there's no sort of physical test like taking somebody's blood pressure in order to say how they're going. It's really a trial and error and are you physically better, and the test results are better. And, as you know, the question can lead to suicide, incapacity, it's a long hospitalisation for many months.

MS ABRAMSON: Just on that though, - - -

PROF KING: Yes, we've read your submission and recognise the importance of matching the individual to the particular antidepressant, for effectiveness of the antidepressant. But one of these - and apologies if I missed it - but we do of course know that antidepressants can have significant side effects and proven suicidal ideation. To what degree is the correct match of the antidepressant relate to those side effects? So I was just wondering, if you - so is it a correct match; not just that the medication is working, that also reduces the side effects?

PROF SHEFFIELD: Yes, absolutely. So, what we're looking at basically is how far the (indistinct) is focused in the (indistinct).

PROF KING: Okay, yes.

PROF SHEFFIELD: Because people vary tremendously. So if the medicine is taken too slowly, for the person who is on a standard dosage every day they will end up with too high a blood level.

PROF KING: Yes.

PROF SHEFFIELD: And we know that blood level has been linked to side effects. And in particular there's something that has only recently been found, it's in the - very well published in the psychiatric literature, the higher the blood level the more side effects there are. And this is one of the major things that the (indistinct words) in any (indistinct). Equally, if it's too fast then the duct may not have (indistinct). And what's been shown that if people are what's called 'ultrarapid metabolisers', very fast metabolisers, then the link with suicide, a greater risk of suicide, and the faster it goes the greater the risk of suicide. So, in both of those situations the (indistinct) genetics can help, the (indistinct) or (indistinct). And not only can they tell the risk of suicide or some of these side effects or when the drug is suitable, but that very thing that when the drug is suitable is that if the first thing the test showed that drug A is not suitable but then the test would actually recommend which ones would be. One of the reasons we think the time is now is that when we started this ten years ago we - that's one of the first principles on what to recommend. We're now international recommendation (indistinct), so that we say that if you're on drug A and you're genetically (indistinct) for B, then the international recommends you should do whatever that recommendation is, and we would print that in the report so the doctor can follow it. So invariably what the doctor wants to know is how is this drug for and what shall I do with it?

PROF KING: Okay.

PROF SHEFFIELD: So that's the basic reason to do it, but we've seen some remarkable changes in people who have gone through this cycle of them not being on the right drug, having terrible side effects, perhaps getting terribly agitated, taking risks or attempted suicide, to ones that have the test, another drug administered and within a few days to weeks they become normal and they have changed dramatically. And we've seen this pattern over and over, it's wonderful and so important (indistinct). Now, - - -

PROF KING: I understand your drug is not covered by the Pharmaceutical Benefits Scheme - or your test is not covered, I should say, by the Pharmaceutical Benefits Scheme at the moment?

PROF SHEFFIELD: No, it isn't. It doesn't have a rebate at the moment for the MBS, the Medical Benefits Scheme. There are some tests that are covered by the Pharmaceutical Benefits for very expensive drugs, they're mainly cancer drugs, but (indistinct words) up.

MS ABRAMSON: Can I ask; are any of the private health insurers able to cover the cost? Normally (indistinct) follow MBS, are there any of the tests that are being paid for by the private health insurers?

PROF SHEFFIELD: Not in Australia, but recently there's been quite a sting of activity in the United States where (indistinct) insurers have taken this up and they can't recommend or (indistinct words) genetics.

MS ABRAMSON: Thank you.

MR ALLAN SHEFFIELD: I might just add to that. It's Allan here. That we accept that United Healthcare, who are the largest health insurer in the US, have recently funded this very area that we're putting our proposal. And in Australia we're met with all the - most of the major health insurers and their chief medical officers, and their view is that it's a pathology test, therefore it's a government issue, not a healthcare - not an issue under insurance. So it sort of got blocked at that time when they sort of pushed it back to government.

PROF KING: Okay, and that answers my next question. So it's – so from the perspective of the health system in Australia, it would be classified as a pathology test and therefore whether it would be covered under MBS or not – okay.

PROF SHEFFIELD: Yes. So we're also aware – and I'm aware of - having been resolved in a couple of tests - that it's gone through the wrong branch to get the Medicare benefits, or MBS benefits. So it takes quite a few years and you have to battle against the fact that they would rather fund just some drugs, or some situations, whilst what we're saying is that everyone who has these sort of drugs would be better off (indistinct).

PROF KING: Yes.

MR ALLAN SHEFFIELD: And that, you know – and it would be worse to say – and I think Les was touching on it – but you know, this year, there's been through the Royal College of Pathologists, a positioning paper which is basically defrauding this type of testing and I guess part of our intent with this proposal to the productivity commission is to say there are real benefits that can happen today that should be considered as opposed to going through a longer, drawn-out process through the typical pathways.

PROF SHEFFIELD: What we say today – I'll just, very briefly – it's now – in the past, people would look at these doctors because the viewers said, well, where are the randomised control clusters? There are now seven randomised control clusters. The next question is where is the cost benefit? There are now four or five cost benefit studies that show significant costs savings for those people who had pharmacogenetic-guided treatment and as I mentioned before, we now have the international recommendations. So the time is now to be able to acquire this.

PROF KING: Yes. So – and I note in your submission you make a specific request, obviously, for your particular pharmogenomic treatment. I guess from our perspective, we wouldn't be making a recommendation for a particular one, simply because that wouldn't be appropriate. We're not clinicians and also, we haven't done a full review of all the

possible pharmogenomic treatments that are available. So I guess what I'd like to ask is -
- -

PROF SHEFFIELD: Can I just direct you in terms of – whilst we have represented it as our company and we know ours is best, (indistinct) now all the major pathology companies are providing this in Australia, and so that we are not pushing towards just us getting this testing.

PROF KING: No, I understand.

PROF SHEFFIELD: It will be available for routine pathology.

PROF KING: Yes. So – yes, but I guess my question is, what – we could make, you know – in terms of pharmogenomics as a group of approaches to improving the efficacy of medication in mental health, what needs fixing? What can we recommend at the government end? Is it that – is the problem that these tests come under – are classified as pathology tests, so there is only a long drawn-out process to get them listed? Would it be better if they were treated in the same way as medicines are treated, so going through PVAC to get listing on the PBS? How can we improve the system? Because in a sense, we will be making recommendations to the government about how the system can be improved. So how can we improve the listing system for these sort of tests? Recognising that, you know, from my own background and the pharmacy inquiry I did a few years ago, everybody knows pharmogenomics is coming down the track and it's going to be a huge benefit to consumers, but no one's quite sure of how it fits in our current system.

MR ALLAN SHEFFIELD: Yes. I mean, I think that you've hit the nail on the head in terms of, it's really stuck between the MSAC and the PBS, sort of, process and therefore, it's - you know, traditionally it's going to get caught up in not really having a way to sort of drive it through to be, you know, it might – as a, you know – I guess as a top priority, sort of, pushed through as something that can be – gain significant efficiencies in mental health, and there needs to be a more streamlined process that international – and guidelines that are, you know, support – or making it more transparent that this testing is now available, elsewhere in the world it's being reimbursed by health insurers and, you know, I suppose we need a bit of process to fast-track it through the government system.

PROF KING: Yes.

MR ALLAN SHEFFIELD: And you know, traditionally, there's obviously benefits on the PBS but there's also benefits – or MSAC, but ultimately in the middle is the patient who's going through months and months of trial and error and, you know, we've spent the last 10 years enabling all the major pathology companies so they now have a service to offer, and ultimately the barrier from the doctor is education and then also cost. So part of what we're proposing is why don't take a hard-to-treat group like, you know, youth mental health, or even, we've been discussing, with some of the recent, I guess, policies around veterans, because in the US, the – since 2014, they have covered the costs for veterans in the US for this type of testing. So say let's take one big group that we can make a big

impact and showcase how it can really make such a tremendous benefit and then maybe make it more broadly available to everybody.

MS ABRAMSON: It's Julie. Can I come back to the private health insurers? Because one of our recommendations is that we would like any restrictions on the private health insurers providing support in the community to be dealt with in the way that they now provide oncology services in the community. So couldn't you have a situation that they can provide – the health insurers can do more in community supporting people in their homes, and at the same time, they would be able to send – to pay for the tests in terms of the efficacy of the drugs. So from our perspective, subject to any actual limitations on that, that's the kind of proposal that could sit quite well with our – letting the insurers do more in the community.

MR ALLAN SHEFFIELD: Yes, I think – I mean, I think that would be a good recommendation. It just, I guess, needs to be – if it's packaged up as part of the home care or as part of the overall service as opposed to purely a diagnostic test - - -

MS ABRAMSON: Yes, that's right. I mean, I think we're very cautious, of course, as you know, about a further cost to the PBS which is, I think, one of the largest costs of the Commonwealth government in this space. So we can have a think about that in the context of the private health insurers, but it would be aligned with their ability to provide services in the community. So I want to have a think about that.

MR ALLAN SHEFFIELD: Yes, and certainly our feedback from GPs and specialists is if it was funded by the health insurers, they would be recommending it to every one of their patients. So there seems to be support. It's just dealing with some of that cost barrier, and it doesn't even necessarily need to be subsidised 100 per cent. It's just the fact that, you know, if you get some of this back through your health insurer, you know, it would mean that it would be much – a far greater uptake by the doctors in their confidence to refer the test and make it accessible to their patients.

MS ABRAMSON: Well, I just think it's kind of an interesting proposition – and now, I'm just having a conversation, to be honest. We're having a look at this, because after all, health insurers do fund a whole range of complimentary therapies in the community. So we'll have a think about it.

PROF KING: Okay.

MR ALLAN SHEFFIELD: Yes. As I said, the feedback that we've had from the medical directive – we've seen – it's sort of been pushing it back to government. So we need to be creative. We have - as Les mentioned, though, we do have, you know, testing for certain drugs servicing childhood leukaemia and oncology where the MBS has basically funded the testing, and the second issue that – or second point is that when we started this journey 10 years ago, the test was hundreds of dollars. You know, at scale, this test is, you know - it would be under \$100 and it's a once-in-a-lifetime test. So you have to do it once and then you've got that information. So yes, one of our points was, well, we think the cost is

now at a point where it's affordable compared to some of these other costs that the health insurers are funding for these programs, the mental health programs, the GP – the price is there and the evidence and the accessibility to pathology. So we think the three of those make it – the timing's good.

MS ABRAMSON: Yes, yes. No, I understand. Thank you.

PROF KING: Thank you very much.

PROF SHEFFIELD: You're welcome. You might be interested, in one of the randomised control trials were the people who were being discharged from hospital to home care and the group that has to go to (indistinct) as part of the going home package, they stayed at home and stayed out of coming back into hospital at a higher rate than the people who didn't.

MS ABRAMSON: Can you send - you would have some contact details for our staff, because I know they've been talking to you - could you send that information through? That would be very interesting.

PROF KING: Yes, if you've got a link to that - the publication that's listed in the RCT, that would be great.

MS ABRAMSON: Yes. Yes.

PROF SHEFFIELD: Yes, I'll send that to, I think, Erin.

MS ABRAMSON: Yes. Yes, yes, yes. Thank you so much.

PROF KING: All right. Thank you very much Les.

MS ABRAMSON: Thank you.

PROF SHEFFIELD: Thanks very much for your time.

PROF KING: Okay. Sorry, we're running late.

MS KRETSCHMANN: Hello, Tanya speaking.

PROF KING: Hello, Tanya. Stephen King and Julie Abramson from the Productivity Commission.

MS KRETSCHMANN: Hello, how are you?

PROF KING: Not too bad. We've got a very strong buzz coming through on the line. Are you on speaker or - - -

MS KRETSCHMANN: No, just let me find the cord.

MS ABRAMSON: We might try ringing you back, sorry.

PROF KING: Yes. I'll actually just try ringing again, if you don't mind?

MS KRETSCHMANN: Yes, that sounds great. Thank you.

PROF KING: All right. Give you a ring in 30. Thanks.

MS KRETSCHMANN: Hello, Tanya speaking.

PROF KING: Hello, Tanya. Yes, still got the - yes, the same. Is that okay for the transcript?

MS ABRAMSON: Yes, well, that should be - - -

PROF KING: Yes, we're getting a nod off the transcript person, so we'll persevere. That's the main thing. Tanya, if you could just introduce yourself? Any organisation to represent, if any, for the transcript and then any introductory comments you'd like to make?

MS KRETSCHMANN: Absolutely, so my name is Tanya Kretschmann and I have a lived and living experience of mental health concerns and suicide, so therefore I'm not necessarily representing any organisation, but I'm representing myself as someone with a lived experience and also using the foundational knowledge that I have based on the representative and advocacy roles that I have at local, state and national levels.

PROF KING: That's brilliant.

MS KRETSCHMANN: In terms of opening comments, I guess there's a couple of things that I just wanted to touch base on today that I thought were either not necessarily thoroughly covered in the draft report or were potentially missing elements.

The first thing is the medical model and speaking to shared perspectives on balancing that with psychosocial models or more personalised care models. The second area of interest that I'm hoping to share is addressing the translational research gap for mental health and also evidence-based practice that then builds the foundation of our typically public health system.

PROF KING: Yes.

MS KRETSCHMANN: The third area of interest is early intervention, so looking more - aside from the prevention, but including some of the gaps that I see in the early intervention organisation. And then finally and very, very briefly just around the systemic acid you see the component and particularly around some of the fundamental infrastructure that we see in order to implement some of the recommendations.

MS ABRAMSON: Tanya, one thing - it's Julie Abramson - that I would say is that we understood that how our draft report came across looked like we thought that the clinical model was at the centre of everything. It's actually not what we were thinking, but we understand why stakeholders would have formed that view, so we're really interested in having that conversation about psychosocial supports.

MS KRETSCHMANN: I see. Yes, I think I - yes, and I could absolutely see that there was an interest in broadening the lens of health and particularly coordinating across government to really addressing the psychosocial determinants of health and you could see obviously from the psychosocial models that were being adjusted to the medical treatment, I think those are still obviously an element of trying to broaden our conception of health and wellbeing and what our - how we conceive treatment to be, broadening that lens beyond the health sector, which brings its own concerns, but also then it seeks to potentially adopt both physical and mental health approaches rather than simply trying to address our mental health approach in isolation, which I think then further - if we're just addressing our mental health approach in isolation, further compounds the struggle that we have in broadening the supports that we need to receive in order to maintain mental wellbeing.

And so for me, I think it's just necessarily highlighting the personalised or universal personalised care approaches that seek to really equate not just social describing, which I know was raised, but really equate community-based supports in alignment to medical models to hopefully then empower those systems to support and reduce some of the burden on our medical based care.

And I think one of the things that stuck out to me, which I think then limits the ability to adopt those process, is utilising the stepped model of care as the primary model to orientate health services.

My lived experience of stepped model of care has been potentially climb up the stairs or coming down those stairs and I think naturally the steps approach naturally and inherently help implement a threshold-based system and when we've got a threshold-based system, particularly in the generic-based environment, then we'd pop that to the extremity, which means they aren't necessarily ever getting a matched level of care in that stepped care based model.

PROF KING: Just on that, so there's a couple of issues from there. So there's two. One we're certainly grappling with, which is how to make it quite clear that, in a sense, psychosocial steps and the clinical steps are separate and so - a simple example; someone with high psychosocial requirements may not be the same as someone with high clinical requirements at any point in time, so the example I've been using is someone - a real life example; someone with hoarding disorder who needed significant housing support, but they were able to hold down their job, were performing fine in most aspects of their life, but they were about to lose their house because it had been deemed a fire risk because of their hoarding and you couldn't access doors and things like that, so we're trying to capture that element, but you know, it's not just a one-size-fits-all sort of step up and down.

But I also want to touch on the other point that you just raised there, which is you tend to get pulled to the edges in such a system. How do we make sure that we avoid that, that we get the services in the middle? And I don't want to use the term 'missing middle' but I will anyway, because everyone else uses it, but in that area where so many services are currently missing?

MS KRETSCHMANN: Well, I think the struggle that we currently have is when we've defined these steps, we've really defined the bounds in which those services can step into and out of, and I think the difficulty there is - I think one of the challenges of potential is one the opportunity is by opening the doors that exist on these steps to allow services to respond across the steps, the steps that are most appropriate, and therefore meet the consumer's needs.

Because I think unfortunately at the moment here, and looking at high intensity or even complex care, the services that can provide that support in those particular streams are constrained to those streams, so potentially can't be responsive and I think that's what I see as the flaw in the stepped model.

Absolutely not a flaw in conceptualisation, they're saying that we need to be able to have a matched care system that has meaning for the care requirements. But when we define those levels we essentially put those doors in place, not just for consumers but for flexibility and services and how and where they can step to respond.

MS ABRAMSON: It's Julie, Tanya, one of the issues is, and Stephen has made this point on a number of occasions, how we design that psycho/social system, if you like to call it that, because at the moment so many services are only available on the basis of a diagnosis, so one of our issues is that in the report we could see where the gaps are in the clinical system and so we could go about thinking well this is what we need to do, but when we looked at psycho/social there were so many different programs that were funded, unfunded and we struggled quite a lot trying to bring a unity to that. So one of our issues is how we would make supports of - in a resource constraint world we would make resources available for people in psycho/social supports, so we're quite interested in what you were just talking about, matching care, do you have some ideas on that?

MS KRETSCHMANN: I think there's piggybacking on what else was happening internationally but I think, for example, the NHS in 2019 released the universal personalised care model, which exists across both the physical health and mental health sector and that seems to work in quadrants rather than in scale but for me that tends to encapsulate then the equation of both clinical and non-clinical services that then facilitate the funding part. I think the reason we've seen so many ad hoc social psycho/social supports that are in and how varied they are in their funding sources is because they haven't been emphasised or even prioritised in their position in providing and supporting wellbeing, which means they haven't been consistently re-funded. And I think it's not until we re-imagine medical and psycho/social supports being equitable supports than just variable depending on an individual's circumstances that we're ever going to see the funding

industries that can create that sustainability that can then match demand which can then take the pressure off the clinical. And I don't think we're going to do that until we start to actually approach the conceptualisation of health care. We're only talking in the mental health ones and we're already putting boundaries on it and then I think we're not even looking at how we will conceptualise it. After all we have poor health and across inter-sector governments and then we are again constraining how we can see it.

MS ABRAMSON: Thank you. Tanya, could I also ask you about you've got a point you've accessed any consumer advocacy structures, what does that look like from your perspective?

MS KRETSCHMANN: I guess that's actually what I wanted to touch on a little bit briefly, I can see the recommends things with around just monitoring and reporting on systemic advocacy. I think for me I'm just very acutely aware that within Queensland and the Northern Territory, between jurisdictions that we don't have peak bodies to really support systemic advocacies and the collation of voices to create impact.

And I think for me what we absolutely need to also look at how we're supporting the consistency and collation of a voice at a national level. I don't think really we can do that until we support the equity of our states and territories to have a voice. And I think particularly in the Northern Territory and Queensland we don't have mechanisms to support systemic advocacies by consumers and carers then already we're at a step – at a disadvantage before we can even step into the national sector.

MS ABRAMSON: Could I just ask you one point on that because I think in Victoria, the State Victorian Government has funded some of that advocacy and certainly all of the states have mental health commissions in various forms, you know, that they're not all the same, the West Australian one is a commissioning model, looking at the Australian - and I will get you to state on the record, but I'm thinking of as a Victorian, to be honest, so do you still see that as - and I'm not being negative about this but do you still see that as a Commonwealth responsibility not something that the states would have a responsibility for?

MS KRETSCHMANN: To be honest I think it's a shared responsibility. I think absolutely at the national peak perspective which is where you're looking at the national agenda, but I think at the Commonwealth we absolutely need to respect that if the states aren't necessarily able to support those agendas then we're at a disadvantage at the national level when those workers aren't heard. And I think until we can support equity of those voices then we're going to continue to see funding and even resources being distributed to where our voice is the loudest and that's not necessarily voices that we're always meant to hear.

MS ABRAMSON: No, that's been very helpful, thank you.

PROF KING: One of the other areas you wanted to touch on was early intervention so which particular issues there would you be wanting to discuss?

MS KRETSCHMANN: For me I think it's - I had the beauty of being able to work in some of our acute services and also community based services in the public health system and I was just absolutely aware that obviously 75 per cent of those who develop mental illness do so before they're 25 years of age. And so for me I've got a particular interest in how we support individuals who have been identified that they're a health concern, particularly in the early developmental years when we can impact on prognoses much greater in those early years of diagnosis than in later years.

And I think at the moment what we have a particular awareness of is that particularly to individuals say 17 years of age to 25 years of age who have entered the adult system, you know, already in a burdened acute adult system that we're not necessarily - we're not meeting the treatment as sensitively as - of all the therapeutic interventions of those individuals because of the demands that exist on the system and the model of the system that exists within adult services.

And I think we're going to try and look at how we assess the due demand to then be able to support the reallocation of resources from our two centres to our prevention sector. But I think one of the key populations that we can do that with is individuals who have an early onset of diagnosis and particularly in those developmental years up to 25 years of age, we the system supports appropriately and adequately won't go on to have enduring illnesses and I think in the existing adult acute systems we don't have the capability of giving the appropriate treatment or even the appropriate dosages to support that recovery.

PROF KING: So in some ways headspace is one of the approaches that's been taken in that area, and headspace is 12 to 25 years of age?

MS KRETSCHMANN: Yes.

PROF KING: Yes, I couldn't remember if it was 14 or 12. Any thoughts on whether that's an effective intervention, should there be more headspace centres or are you thinking - what are you thinking of there, Tanya?

MS KRETSCHMANN: To be honest I'm thinking - I think the legal thing of headspace is an alternate concern, I think from my perspective is we're seeing too much of a demand on our public health services for up to 25, which means that our headspaces have catered to the more moderate to severe end when they were primarily or originally developed for that low to moderate mental health concerns end of the spectrum.

I think there's a whole other band of concern that fits to their effectiveness there, but I think for me it's potentially the development of transitional services for the acute sector to appropriately respond to those individuals. Because I think at the moment individuals who have an acute presentation, which many do, under the age of 25, aren't necessarily well supported in our community care so they are popped into our all youth services but then all adult services are not necessarily supported there.

So I think absolutely headspace does a remarkable job for the community sector but I think

the group of cohorts that I'm particularly concerned about is those who are above that threshold for headspace but who absolutely are falling short to receiving appropriate care in our adult acute system.

PROF KING: Yes, and the issue of things like child and adolescent beds in public hospitals even, yes, so the gaps in the system there.

MS KRETSCHMANN: Yes, or even not necessarily being across the board, our services not being able to provide therapeutic intervention and so that missed opportunity of being able to really get in early and have an impact on development.

PROF KING: Thank you for that.

MS ABRAMSON: You've been incredibly helpful. Really, we'll have a good think about some of the things that you've said today, so thank you so much for making time available for us.

MS KRETSCHMANN: Thank you, and I guess – I think the only thing that I really wanted to, I guess, hit home about is, yes, our translational research gap on any individual who didn't get onto our service line (indistinct) treatment, and unfortunately, there's a 17-year turnaround. I don't want to wait another 17 years to find out my (indistinct) chance of recovery, and so for me, I think, underpinning what is ultimately delivered to (indistinct) and carers, if we can improve the efficiency with which we can get it into our hands to be tried, to be tested and to include that whole of your life, the better outcomes start, I think. Ultimately, at the end of the day, that's really interesting, our translational research, and I don't necessarily feel as if that's being picked up in the other court.

MS ABRAMSON: No, we'll have a think. Thank you so much for your evidence today.

PROF KING: Thank you.

MS ABRAMSON: Thank you. Bye.

PROF KING: And if you could just state your names and your organisation, and any comments you would like to make for the transcript, and Matt is bringing water.

MS HARRIS: Is this okay here?

PROF KING: Yes. They're just for the transcript, so if you can speak up.

MS HARRIS: Yes, okay. My name's Vanessa Harris and I'm the executive officer for the Northern Territory Mental Health Coalition.

MS DAVIS: And I'm Judy Davis. I'm the chair of the board of the Northern Territory Mental Health Coalition.

MS HARRIS: Yes. We've just prepared a statement because there's been a lot we've written in the April submission we wrote and we've just responded.

MS DAVIS: And we've read yours, of course.

MS HARRIS: Yes, and we've responded to the draft one that's just – that closed in late January. I think one of the couple of points we just want to make listening to some of the interesting information that you're gathering from other people was that we actually don't have a mental health commission here in the Northern Territory at all and we actually don't have an independent chief psychiatrist advising the health minister here or the Northern Territory Department of Health. So that's been a bit of a lag for us and it's been over two years, I think maybe longer. But it's been quite a hindrance for us in the community mental health sector. So I've got a bit of a statement with me.

PROF KING: Sorry, just on that point - - -

MS HARRIS: Yes?

PROF KING: Do you mean it's been over two years – so the – is it the (indistinct) of chief psychiatrists but it hasn't been filled for two years? What's the - - -

MS HARRIS: They're restructuring.

PROF KING: Okay, yes.

MS ABRAMSON: And could I just ask on the mental health commission, is the – and my apologies for - - -

MS HARRIS: That's all right.

MS ABRAMSON: - - - because I'm sure somebody will have told me that at some stage – is there nothing within the health department itself? Because not everybody has standalone mental health commissions. So is there no kind of – nothing?

MS HARRIS: No. There's nothing here in the NT.

MS ABRAMSON: Thanks.

MS HARRIS: So – and that independence around that advising is not here for us.

MS ABRAMSON: Yes. No, I understand.

MS HARRIS: So Peggy Brown was very good for five minutes and then Denise – Dr Denise Riordan came for a little bit longer, and then we haven't had anybody, and we want people who sit outside the tent.

MS ABRAMSON: No, I understand that.

MS HARRIS: We don't want them to be a pay packet from the NT health department because that's not an advisor. That's an employee.

MS ABRAMSON: No, we understand that. It was more - understand that there actually wasn't something.

MS HARRIS: No, there's nothing.

MS ABRAMSON: Thank you. This is why we do our original visit, by the way.

MS DAVIS: And I guess we're speaking from the NT context today and representing the needs of this jurisdiction.

MS ABRAMSON: Yes, absolutely.

MS HARRIS: So I suppose a little bit about us is that we're the peak body for community-managed mental health services here across the Northern Territory. One of the things - when the Commission said we were going to the inquiry, we contacted a whole lot of organisations in January last year - the legal services, housing, the Aboriginal community-controlled, AMPs and the peak - and we gathered everybody together for a bit of a meeting to see how we'd write. I think this was a really good opportunity when the mental health commission opened this up to social determinants because there wasn't really a voice around the legal - how people who are unwell are intersecting with the courts, it's not really clear, the mental health that impacts on housing - so this was a really great opportunity and I commend you for opening up to the social determinant mental health in January 2019.

So I think a little bit about us is our vision was for all Territorians to have the opportunity for the best possible health and wellbeing. Some of - the purposes we have is a strong voice for mental health and wellbeing in the Northern Territory. The Coalition welcomes this opportunity to contribute to the Productivities inquiry into the social and economic benefits of improving mental health. We support the Commission's view that there are many factors in addition to mental health service that can improve mental health and lead to greater economic participation, enhance productivity and economic growth. As the peak for - the body for Northern Territory community mental health, the focus of our submission was to highlight the diverse populations, the vast distances, the thin economic markets and the complexities inherent in delivering adequate appropriate services in such an environment.

The complexities - the Coalition seeks to facilitate an accredited and supported mental health system across the Northern Territory where community mental health is available for all Territorians. That encompasses the full spectrum of prevention, early intervention, treatment in people's local area and in their towns with low and no barrier to access. So what we're also asking is that it is fully integrated with other services that may be available as well staffed by trade-knowledgeable people, including peer workers, at times of the

day/week/year when support is most needed, and we also ask that in a culturally safe, respectful manner inclusive of participants' families and their communities, and that demonstrates long-term trust, consistency and commitment, which we haven't had in the Northern Territory around mental health for a very long time.

The Northern Territory, sort of, context of how we are working here is that there's a range of complexities – interrelated factors that impact on accessibility and quantity of mental health services in rural, remote in the Northern Territory. However, the accessibility and quality of mental health services cannot be considered in isolation from the specific social/economic disadvantage and intergenerational trauma experiences by many Aboriginal and Torres Strait Islander communities in the NT. Social/economic factors that contribute to the significant burden of poor mental health in this population include overcrowding, poorly maintained housing, high burden of chronic disease, high levels of homelessness, overt institutional discrimination and low level of education, detainment and employment. The mental health burden of disease is much higher in the NT compared to national average. In the NT, mental health conditions contribute to 16.3 per cent of the burden of disease, compared to 7.4 per cent in Australia as a whole.

Young Territorians are over-represented within mental health services compared to other age groups, with young people aged between 15 to 24 years constituting 25 per cent of all community-based clients, despite being only 15 per cent of the population. So almost a quarter, which is 23.3 per cent, of Aboriginal and Torres Strait Islander Territorians experience high – very high – psychosocial distress, also twice the national average of 11.8 per cent. The NT experiences a rate of death by suicide of six times the national average. Upstream social determinants such as poverty, unemployment, drug and alcohol use, family violence, chronic disease, ongoing grief, loss due to high rates of mortality and imprisonment, are central to the disproportional high rates of suicide and psychosocial distress experienced by Aboriginal and Torres Strait Islander people in the NT. These issues heighten the need for accessible, culturally safe, high quality mental health services and for whole-of-government strategies to address social and economic disadvantage.

MS DAVIS: So I guess Vanessa's painted the picture of what we're dealing with in the Northern Territory in terms of mental health here and our mental health care. So I'm going to go on and talk a little bit about the provision of services here and I guess the biggest issue here is the scarcity of the services.

MS ABRAMSON: Yes.

MS DAVIS: So we have a scarcity of services across the healthcare spectrum, from low-to high-intensity, and it's a significant cause of low access rates amongst particularly rural and remote communities here. The widely dispersed and comparatively small rural and remote populations of the Northern Territory is supported by a mental health system that is skewed towards high intensity services which are often under-resourced and tasked with providing mental health care across vast and isolated regions. It's notable that the Barkly region alone is larger than the state of Victoria, yet its many remote communities are serviced primarily by a small number of NT Department of Health and non-government

mental health practitioners based in Tennant Creek, which is a long way from a lot of those communities.

The evidence that is available to us at the moment demonstrates that there are significant economic as well as social benefits for investing in prevention and early-intervention, and I think you've been hearing that today and we'd like to see a focus there, particularly focusing on young people with mental health.

However, in many remote communities across the NT, low-intensity prevention and early-intervention services are largely unavailable - and we know this from the work that we've done in gathering providers and others together, to talk about that - with child and adolescent services being particularly under-resourced across the Northern Territory.

We welcome the opportunity to make the recent submission to the Productivity Commission draft report, and we highlight in particular the draft report's recognition of a number of factors, including the need for access to culturally safe, person-centred care within a stepped-care model; the critical role for consumers and carers in guiding system improvements; a focus on prevention and early-intervention; and improved data collection, monitoring, and evaluation. We think that that's an important part of the model.

However, the Northern Territory Mental Health Coalition has outlined a number of key concerns for reform in this jurisdiction; a primary concern is that the draft recommendations may inadvertently exacerbate already difficult situations, such as those that exist here in the NT.

With respect, we feel that the Commission would be well-placed to give further consideration to the implications of the draft recommendations in complex environments, such as the provision of services in disadvantaged, rural, remote and very remote areas across the Northern Territory. We ask for further consideration of the critical role of community-based mental services in particular, to adequately address the service access, integration and co-ordination of care across stepped-care models, in order to realise improvements in mental health, particularly in our most vulnerable population groups, right across the NT as well.

The Coalition and our membership makes itself available to assist the Commission to gain a clear understanding of the role and value of that non-government community mental health sector within a mental health system. So I guess that's our key message to the Commission today.

MS ABRAMSON: Thank you.

PROF KING: Just start by following-up on that last part with the two directors. So thank you, Vanessa for the opening comments. So I guess our approach to thinking about services, not just in rural and remote areas, but in all areas of Australia, is to try and set up a structure, particularly for psychosocial supports.

So a starting point is that it's very ad hoc, it's ad hoc funding, pull the funding, fly-in, fly-out, you don't know if the funding is going to continue. So to try and stabilise that system and to create a funding system that could be regionally focused, to make sure that what is needed - what is needed in central Melbourne is completely different from what is needed in (indistinct) region.

And that was really behind our regional funding approach. We had alternative models presented, which we asked for information on. But yes, looking through your submission on the first draft submission I thought, "Well, is that approach wrong or have we been at too high a level, so that the providers on the ground can't see what we're trying to do?"

Because your view is we've sort of missed it, and so I'd really like to get into more detail.

MS DAVIS: Did you want to extend on that, or?

MS HARRIS: Yes. Look, I think we're not saying you've missed it; we just actually haven't had a chance to really workshop and think about it a bit better. Because I think one of the things we have in the NT is, we have only two funding providers here for us: the Northern Territory Government and the NTPHN, NT Primary Health Network. They're the only two here.

Now, I'm not going to make comment on whether they're working efficiently or effectively, or even co-designing or whatever they do, but what we're saying is, if you put another layer into that system, it then makes what we've got at the moment extremely more complicated than what we've got. So it's probably the devil you know, rather than the devil you don't at the moment.

So if we could have more, you know, time to look at what that third model looks like, given we've got two models already in the NT? They're the only funding bodies here in the NT, only funding providers.

PROF KING: I guess our build model was to say, well, part of the problem - in other words, well actually you can say it is the problem, easily. We have received other evidence to say that there is a lack of co-ordination in the NT between the NT Government and the PHN, and one of the approaches that we were trying to do with a regional commissioning authority as one of the alternatives was to say, "Well, let's bring the mental health money from the PHN," which is about 60 per cent of our budget, "together with the Northern Territory Government mental health money, separate it off from government in through a regional commissioning authority, so that there would be one body to co-ordinate the services.

And the aim or objective there is partly to avoid the problems of co-ordination, which we see in the Northern Territory but we also see elsewhere in Australia. So any thoughts on that?

MS DAVIS: And I think there's been numerous needs assessments done across all, you know, parts of the healthcare model in the Northern Territory, and the number one has always been the lack of co-ordination and integration across services. So it is a big problem to solve, I guess, and I guess certainly something that bringing the money together so that you can address the needs.

But I guess what we're saying is, the needs are different, particularly rural and remote, and very remote in particular, and they're probably greater. And we're also dealing with all of the social determinants as well, so we have a system that needs to give consideration to the social determinants and where we're at in terms of really taking a holistic and more comprehensive approach to resolving our mental health concerns here.

MS HARRIS: And I think the PHN, in all its worldly way it works, is that they're very active in funding Aboriginal organisations to deliver mental health services. I absolutely don't have any issue with that as the peak body for community mental health, but I think we need to also keep thinking that people who are receiving services have a right of choice of service, okay?

If they don't choose to go to an Aboriginal medical service where there are social and emotional wellbeing programs funded through the Commonwealth government, funded through the PHN, funded through the NT Government, they go to another service which might be one of our mainstream services, and feel that they get a better service there. They still have a right of choice of service.

PROF KING: So I completely understand; that argument has definitely been put up to us, but particularly in the higher population density parts of Australia. So you mentioned Tennant Creek before, so if we take say, Tennant Creek; is the population there - and if we brought them out into the Barkly Region, is it sufficient to actually sustain multiple services so that you can have that choice? Or is it the case that simple practicalities mean that there will be only one service that's viable?

And then it can be a choice: well, is that say, an ACCHO delivered service, or is that a service delivered by a non-indigenous NGO? Put those aside for one moment, exactly who the service provider is, but just coming back to actually, is that choice realistic outside Darwin and possibly Alice Springs? In the NT, is that choice realistic?

MS HARRIS: Well, I'll give you an example, Tennant Creek doesn't have a bulkbilling GP.

PROF KING: Yes.

MS HARRIS: So, there is no choice in Tennant Creek at the moment.

PROF KING: Yes, that's what I mean.

MS HARRIS: It's either the hospital or the Aboriginal Medical Service.

PROF KING: Yes.

MS HARRIS: So, if you don't feel comfortable at the Aboriginal Medical Service and you're an Aboriginal person, you're accessing the hospital.

PROF KING: Yes, but what I'm getting at is - - -

MS HARRIS: Yes, I know what you're saying.

PROF KING: - - - that's just simply driven by population and the economics, but you can't – for a small population base, you can't allow that choice. I'm just putting forward a view.

MS HARRIS: Yes, but I think you also need to consider that the Aboriginal community control haven't been caught up in the NDIS. A lot of them haven't signed up here in the NT. There's only two that have signed up because they have PIR and PHAMS. So, their funding is from the Federal Government. It's pretty well set. It's pretty well – you know – so, I think some of that is that the PHN also support a lot of that work in that they lobby like the rest of us to get funding as well.

I think that money for mental health is tied through the grants that come in from the Federal Government to the community control. Now, my service is having to build through the NDIS, so we're all subject to the NDIS and their clients being participants of the NDIS.

MS DAVIS: I guess we've talked a lot about early intervention and prevention and making sure that there's investment there and I think there are a lot of community mental health providers and other providers out there that are doing that work. They're working with families. They're working with children or have the capacity, certainly have the capacity to do that, which will then have flow-on effects to the mental health system.

It will have social and economic benefit to the mental health system. So, ensuring that the community providers are adequately accessed to provide a range of options for people to access services is important and that it's a part of the system that also needs attention I guess.

PROF KING: I wanted to go to the workforce.

MS ABRAMSON: I was going to ask about the workforce. One of the things that is really apparent in the Territory and you mentioned, Vanessa, really thin markets and so lack of people who can provide the services. We've been thinking a lot about this issue you would have seen in our report.

The answer in some areas is telehealth but that's not the answer to everything. So, I'm just interested in what we can do around the workforce?

MS HARRIS: We've just undertaken a project late last year, 2019. We got some really good support and funding from the NTPAG and we looked at workforce around the mental health peer support workforce and we engaged Wellways in Victoria. So, that has been very successful for us. It was a pilot just up here.

MS ABRAMSON: Yes.

MS HARRIS: There is no peer support network here. There is no linked experience network here. We've been working really hard and applying for quite a lot of money and just been knocked back every which way. We have started with Wellways and it came up and we had a steering committee. We had 55 applications for the – we contextualised the tender to a six and 22 started and 17 graduated from the six-day program. All identified with mental health lived experience.

MS ABRAMSON: Yes.

MS HARRIS: Wellways sent two trainers up, very experienced trainers, that worked through those six days with these participants, and then they went on in August just recently to do the facilitator training. Now, they're actually out there training in pairs. They run a men's program through one of the Aboriginal rehab services and they're just at the moment running another women's program, then they'll do a joint one.

So, we have actually given a bit of a career path to people who haven't worked for a long time because of their mental illness, but also now are facilitators. Because they haven't worked for a long time, we have employed them as casual employees for this part of the project to then facilitate and deliver the programs, My Recovery program. So, what we have been trying to do is grow our own peer support workforce. That's what we're trying to do as a peak.

MS ABRAMSON: I should know those because I have read the submission. Is one of them in the submission, that program that you just talked about, your pilot?

MS HARRIS: No, I can send you some reports on that.

MS ABRAMSON: That would be fabulous because it sounds like a really interesting – I don't remember in the submission. It sounds like a really interesting program.

MS HARRIS: Yes. We did a needs assessment first with some funding for the PHN around who is doing peer support, what does it look like. We looked around Australian through the Community Mental Health Sector, which is CMHA.

MS ABRAMSON: Yes.

MS HARRIS: Then we looked internally and then we started this project. So, we've just reported it to the PHN around that, so I would be happy to talk to you about that report and what it looks like.

MS ABRAMSON: We'd be really interested, thank you. You've got the email for our staff?

MS HARRIS: For Erin, yes, we have.

MS ABRAMSON: Absolutely, thank you.

MS HARRIS: We've also been invited to participate as the NT in the Mental Health Commission developing – I think it is guidelines around the peer support for national.

MS ABRAMSON: The Mental Health Commission, yes.

MS HARRIS: So, they've had our voice in that as well which has been really interesting for us.

MS DAVIS: Yes. I mean it's an approach that builds the capacity and the strength and builds on the strength of community to be able to address the issues that exist within communities.

PROF KING: Thank you, Vanessa. Thank you, Judy.

MS HARRIS: Thank you.

MS ABRAMSON: Thank you. I will remember now about the Mental Health Commission or lack thereof in the Northern Territory, the lack thereof of this experienced workforce and the lack thereof of consumer choice.

MS DAVIS: Thank you.

PROF KING: Next the Mental Health Association, is it? Merrilee, if you could just for the transcript state your name and your organisation and any opening comments you'd like to make.

MS COX: Thank you. My name is Merrilee Cox and I'm the chief executive office of the Mental Health Association of Central Australia. Thank you for the opportunity to present today, to talk today. As you will be aware, I did submit a written submission.

MS ABRAMSON: Yes.

MS COX: I won't spend a lot of time going back over those things that were commented on, other than to say that I think it's a really welcome discussion being promoted through this process, and I thought the report was a fantastic exploration of the range of issues.

Some of the things that I wanted to talk to today is about that Australian and also the Northern Territory, we're not a level playing field.

MS ABRAMSON: Yes.

MS COX: I know you're well aware of that but I think it's a really significant issue.

MS ABRAMSON: We've seen that in some of other reports, Merrilee, that you would be across.

MS COX: That's right. I think that for our sector, the NGO sector - so we're a member of the coalition and actively involved and support that submission as well - I think one of the issues is that there has been a significant under investment in psychosocial support services here.

Because we are a Territory, unlike the States where probably in the past about two-thirds of the funds going into mental health came through the State and a third came through the Commonwealth through the new initiatives, we're around the other way. So, we were really reliant on the Commonwealth programs, like PHAMS and PIR, for the expansion of the sector, and there hasn't been any significant increase in the investment by the NT Government in the psychosocial support sector for a very, very long time.

I think the other issue to speak to, the one which comes up about the lack of an NT Mental Health Commission, or the also only very short lived period with which we had a Chief Psychiatrist, is that we haven't had that for the leadership and conceptualisation of what the role and function of the NGO sector is.

What that means also, and I think this is an issue beyond just health services, is that our service is not well designed and it doesn't match the needs. As an example, there's no Aboriginal Mental Health Policy in the Northern Territory, despite the fact, as Vanessa and Judy spoke to, it's a significant proportion of our population. We work in a cross-cultural context but we have no policy, broad policy framework or practice framework or investment in thinking about what is the significance of working in this particular cross-cultural context and what are the expectations and the appropriate building blocks of the service system in this context.

Likewise, we have no dual diagnosis capacity at all in the Northern Territory. We have significant issues of alcohol and other drug use as a very big contributor to both suicidality and to mental health difficulties, but no dual diagnosis framework system, not one scrap of funding going into that dual diagnosis area.

Likewise, we have some of the highest level of cognitive disability in the country and there is no brain disorder or ABI services at all in the Northern Territory. We don't have a strong match between the profile and needs of the population and the services that are available, and though this is not mental health, it (indistinct) on mental health.

There is no Auslan interpreter outside of Darwin, yet we have the highest incidence of hearing impairment in the whole of the country. What we see is that we've got a really big

mismatch between the profile of the people and the kinds of services that are available, and so the design work hasn't been done around our system.

I think that was one of the exciting elements of your report and I think you talked about that need to go back and think about the redesign and then a commissioning process that allows that redesign to occur. So, that was one of the things that I found really exciting about reading your report is going back and thinking about that.

I guess one of the other things about working in this constituency is also a thought about how funding is arrived at. We've currently got a piece of funding that's population-based funding. It's the national psychosocial measure which is supposed to equip our organisations responding to new and emerging mental health difficulties in the context of NDIS. Because that's a population-based piece of funding, channelled by the Department of Health through the PHN, that's \$16,000 a year.

MS ABRAMSON: Your need is like this and your funding is like this.

MS COX: That's right. So, you have \$16,000 and then alongside that \$16,000 goes the requirement to do two different kinds of monthly reporting, two different kinds of quarterly reporting, participation in meetings and forums and goodness knows what, which really probably pretty much eats up your \$16,000 a year. We've sort of also got into that position where we've got - if it is population based, it's problematic. We've actually got to start to think about how we arrive at an appropriate level of funding that is actually responsive to the need because it's a bit of a joke, \$16,000.

MS ABRAMSON: Do you have some ideas on that?

MS COX: Well, my thoughts are about us needing to have more of that discussion around the loading and the framework and I know that that was one of the things under the current National Mental Health and Suicide Prevention Plan was to go back and have a look at how those funding agreements were reached and the way that loading should work. I think it's been very publicly acknowledged at the Federal level that having a high indigenous population lends itself to the need to think about it a bit differently than you might in a different setting.

MS ABRAMSON: Yes.

MS COX: In many ways, I think that they were some of the key things that I wanted to talk about, but I think you also raised the issue of workforce.

MS ABRAMSON: Yes.

MS COX: I'm sure you've heard this before, but we have to build – workforce is one of the key reasons why nothing much has changed for a long time in the shape of our services because every service is limited by the need for a skilled, appropriate workforce. Just this week, I was speaking to the Royal Flying Doctor Service which is responsible for doing

some of the primary mental health care in remoter settings, where they fly in and out on a six-week basis.

MS ABRAMSON: Yes.

MS COX: At the moment, because they are down three staff, they can't travel. So, what can happen, services just come to a dead stop in the Northern Territory in a way it doesn't happen in other settings.

MS ABRAMSON: Yes.

MS COX: It's the tyranny of distance and the issues of safety and so on which can really prevent those things happening. I think we have to be investing in the community. We need to be building capacity at a local community level.

MS ABRAMSON: What does that look like? I mean we talked about the peer support and the Productivity Commission is absolutely there, and we've got some recommendations.

PROF KING: Yes.

MS ABRAMSON: So, interested in some of that research. What does it look like for you?

MS COX: Well, there used to be in the Northern Territory a commitment to the development of an Aboriginal mental health workforce, so that within local health services or within the local community mental health service, there was an Aboriginal mental health worker. They were people drawn from the local community who were assisted to develop the knowledge and understanding of what a framework of mental health looks like and to work in that sort of bridge-building way to support the engagement of community into those services.

There has been a really successful model implemented at Miwatj which is in East Arnhem Land where they have worked really strongly to do that using the Partners in Recovery funding as the vehicle for that over many years.

MS ABRAMSON: Yes.

MS COX: I think we need to look at those models where that has really worked and try to spread that out into other areas because unless we do – if we rely on a workforce that is all those young people that coming up from the southern and eastern States who are interested in an experience and then leave again after a couple of years, we get churn and we never get innovation and we never get that sort of maturation of service delivery. When I first moved to the Northern Territory, I was so shocked. I felt like I was about 25 years back in terms of the delivery of services, and also the engagement across clinical and non-clinical.

I think Tanya spoke a little bit to that where sometimes though the delineations themselves prove problematic. I think we have to invest in workforce and we have to build capability at a local level so that we can then start to build on top of that.

MS ABRAMSON: One of our biggest challenges, I guess, and we spoke a bit about this before, is when we looked at psychosocial, we couldn't see a system. But whatever we build, we have to build it in a way that it's responsive to local needs and that's the hard thing.

MS COX: Yes.

MS ABRAMSON: Because you're talking about NDIS, well that big program that's rolled out across Australia and we're thinking about, as Steven said with the commissioning, we wanted to match local needs, local planning needs with actually the need for particular services. So, it's kind of where we've landed there.

MS COX: Yes, and I understand that.

MS ABRAMSON: Sorry, Merrilee, one of my staff was just asking, the \$16,000 that you've got, how many people was that supposed to cover?

MS COX: It's for new and emerging mental health needs in the community. So, it doesn't specifically say but it does ask us to report on it.

MS ABRAMSON: Yes.

MS COX: Because there's no capacity really, it's not even a full day of an experienced worker's role, we're using it for the purpose of a referral.

MS ABRAMSON: Yes.

MS COX: We get between two and three referrals a week. So, if we do an adequate assessment of those two or three people, then we channel them back through the stepped care model because people in the community don't actually understand mental health care at all. That's how we're using it. We've sort of set up like a centralised sort of intake referral into the organisation because that's the only meaningful way that we can think of to do something useful with it.

MS ABRAMSON: Yes.

MS COX: I think as there is more awareness around mental health and more acceptance in the community or the de-stigmatisation of mental health, more and more people are coming to services like ours and asking us for support. When our services were established, we were mainly working with people with severe and enduring mental illness.

MS ABRAMSON: Yes.

MS COX: The only real investment in that earlier intervention and primary mental health space has really been the ATAPS initiative and it's not the appropriate response for a lot of people.

MS ABRAMSON: Yes.

MS COX: It works for some people but it's not the appropriate response and I definitely don't think it's the appropriate response for many of the people in our communities because of the issues that were raised before about all of those systemic issues that people experience.

In Alice Springs, our homelessness rate is 18 times that of the national homelessness rate and our rentals. So, to rent a property is somewhat similar to renting in Sydney. It's different to Darwin in that there's really different profiles. It depends where you are in the Northern Territory. In Darwin there's a very depressed property market which is sad if you own a property, but it has led to a more affordable rental, private rental. In Alice Springs, a one-bedroom flat sort of starts at about \$380 a week, so it's absolutely beyond that are on any kind of welfare income, so we have massive homelessness.

Sending someone off to attend psychology sessions when you're homeless and have no running water and nowhere to wash your clothes, it feels tokenistic at best. We need to be sort of thinking about that. You could talk about it as early intervention or talk about it as that primary mental health care space. Essentially, in that space a lot of the work that needs to be done is helping people to negotiate and deal with the social conditions in which they're living.

MS ABRAMSON: Yes, it's interesting because as you will have noted in our report, we had a very strong emphasis on housing.

MS COX: Yes.

MS ABRAMSON: It was very clear for us from day one that this was a really – somebody cannot function at the level they might be able to if they've got insecure housing issues.

MS COX: That's right, yes.

PROF KING: Just one point. You were here for the earlier discussion with the Northern Territory Mental Health Coalition on choice. Any thoughts on that discussion, the issue of choice and consumer choice which in a sense often lies often lies at the heart of the Productivity Commission work, but dealing with that in areas which have low population.

MS COX: I really don't feel very equipped to respond to that. I think it's very difficult but I think it's also very telling that it is a great deal of stigma about serious mental illness and in the Aboriginal community as well. I think there is also extremely low mental health literacy in that population and I think that sometimes and quite often where people are

welcome is in a mainstream service in the sense of the psychosocial support people are accommodated well in that setting, perhaps because of that greater level of mental health literacy.

PROF KING: Thank you very much.

MS ABRAMSON: Thank you. That's been terrific.

MS COX: Thank you.

MS ABRAMSON: Thank you.

PROF KING: Let's now take a break for lunch. If we can recommence at 2 o'clock.

ADJOURNED

[1.02 pm]

RESUMED

[2.00 pm]

MS RYAN: Hello, Trinity speaking.

PROF KING: Hello Trinity, it's Stephen King and Julie Abramson from the Productivity Commission.

MS RYAN: Hi.

PROF KING: Hi. Can you just give us a minute? I've just got to go through the formalities to recommence the hearing and then pass over to you. So let me just recommence the hearing after lunch, and Trinity, if you would be able to state your name, just for the transcript, and any introductory points that you would like to make.

MS RYAN: Okay. Hi, my name is Trinity Ryan. I am speaking as an individual and everything I say is from my own perspective. Thank you for allowing me the opportunity to speak. I've been a consumer of the mental health system for about 20 years. My diagnosis is schizoaffective disorder, a severe mental illness, in my case involving symptoms such as psychosis and severe depression. I manage to work part time and live alone, yet do still require support. I will need medications for my entire life, and a psychiatrist who will work with me to manage those. I also require case management and counselling support. This in itself is time-consuming and means I am limited in how much I can work.

This is why I strongly believe that the disability support system needs to be made more accessible to those with a persistent mental illness who are working part time. I have not worked more than 15 hours in a week for the past two years due to my mental health

condition, yet was deemed ineligible despite doctors' evidence. In fact, I never even met with an assessor or discovered why my claim had been rejected. Doctors' evidence with up-to-date assessment tools should be used to prove the DSP application. When instead relying on outdated testing models and unskilled workers, too many people are going without the assistance they require. The difference in payments between the Newstart and the Disability Support Pension is extreme, particularly difficult for those already on a tight budget. This can lead to people feeling they are being punished for working or for looking for work, thereby removing any incentive. For example, someone with a severe diagnosis and prognosis who is able to work part time despite it being extremely difficult and often detrimental to their wellbeing may not receive the help they need. To enable people to work part time while not rejecting claims on this basis would allow those with a severe mental illness to feel supported while contributing to the workforce, thereby encouraging those on the DSP to work when and if they are able.

The financial burden of medication for a consumer, especially those without a concession card, should not be underestimated. While concession cards greatly bring down the cost of medication, there are those who are living on lower incomes yet are past the threshold for the low income healthcare card. Affordability can become a problem when forced to choose between buying expensive medications and food. If the low income healthcare card or something similar was made applicable to a wider range of people, including those forced to remain on multiple expensive prescriptions, the consumer would be more likely to be able to afford their medication. Although I am able to manage my illness myself the majority of the time, needing ongoing prescriptions means that I also need to see a psychiatrist with whom I can build a therapeutic rapport. These medications are highly complex, with seemingly similar drugs having very different side effects and benefits. With such complex medications along with even more complicated symptoms, ongoing visits are necessary to ensure my treatment is kept up-to-date.

When altering medications, it can be necessary to see an experienced doctor multiple times in a week in order to make adjustments. This can only be done if the client has affordable access to a doctor they can trust. Any debt that a consumer has to pay through the MBS piles up when the frequency of sessions is so high. Finding a psychiatrist that bills under the MBS is not possible either. Currently, affordable psychiatric care is unavailable until crisis point is already reached. This exacerbates the person's condition and greatly extends the length of time required for recovery. This in turn places further pressure on an already overwhelmed health system, particularly at this emergency level where services are needed most. While in some cases the care of a psychologist is sufficient, in other cases, the expertise and training of a psychiatrist is required. In these cases, it is far more efficient to provide preventative care than to wait until that crisis point is reached. As psychiatrists outside of the public health system are highly expensive, with, at a proper cost, well into the hundreds threshold sessions, maintaining a useful therapeutic relationship becomes impossible for many. In short, we need better ways of funding psychiatry for those who need it most.

The largest barrier to my personal productivity has been stigma and bullying within the workplace. I want to clarify this was in a previous job. In my current position, I am treated

with dignity and respect. I was bullied for a period of about six months before finally leaving the former job. During that time, the store manager was verbally abusive, shouting at me both on the shop floor and in the office. I was questioned consistently about my medications and told they are ‘just like Panadol, up the dose if you need to’. This constant questioning and abuse exacerbated my condition, causing my self-esteem to become dangerously low. My physical health suffered further, as I was not permitted to take rostered breaks at work and was forced to skip meals because of it. With a BMI of about 15 and weighing 34 kilograms, my body had begun to consume itself. This led to such heavy bleeding and intense pain that I believed I was having a miscarriage.

PROF KING: Take your time, Trinity, and thank you, because we have read your submission where you outline the details.

MS RYAN: Sure. My performance was then managed for taking a day off to see a doctor. Shortly after, I was suicidal. Once crisis services intervened, they were able to assist with my mental health but not my situation at work, as they were not equipped with any WorkSafe information. Although I have regained my confidence and the weight over the two years since I left, I am still unable to physically have a child due to the damage done. I don’t know if I will ever be able to. When I did take the case to WorkSafe, I was informed by the business’ insurance company that due to my pre-existing conditions, the manager could treat me however they like.

This is unacceptable. In terms of workplace health and safety, with particular regards to stigma and bullying, we do have pre-existing laws. These laws, however, need to be strengthened and reinforced by holding those with health compliance laws. There needs to be WorkSafe representation for employees in matters of stigma and bullying. While I agree that no-liability psychiatric sessions are a start for this reform, the employee remains under-represented in these matters. In addition to this, due to the psychological impact of bullying, employees may find that they are incapable of presenting their case to WorkSafe at that time. They require support through this already traumatic process in order to achieve the outcome they deserve and return to work as fast as possible. A longer time frame in which to make a complaint would also assist workers to focus on their recovery first, making it less stressful. In cases where the employers fail to meet their responsibilities, I would suggest a compulsory education program based around stigma reduction in a workplace. In this way, the overall standard of workplace health and safety expectations can be lifted, thereby reducing ignorance in the workplace and providing a more inclusive society for all of us. Thank you.

PROF KING: Thank you, Trinity.

MS ABRAMSON: Thank you very much, because I’m sure it’s very difficult to give this type of evidence. What I wanted to know, Trinity, was in your current employment, focusing on the positive, what is it about that workplace that makes it an inclusive workplace for you?

MS RYAN: From a management level down, they have instated programs such as mental health training for all managers. They've really taken initiative to go above and beyond the normal expectations of what a large retailer would. So things like promoting mental health in the workplace, mental health days and things like that, mental health awareness. Even just little things like having fruit available in the tea room constantly, making sure that each other feels valid as a team, not as a – picking on any one individual.

MS ABRAMSON: Trinity, are there any – one of the things that we were looking at is the type of leave that's available to employees, and so were there any particular things about where you work that are very helpful for you? Like, you know, in terms of needing a medical certificate for a day off or a particular attitude to those things?

MS RYAN: I would say that the flexibility of where I work is very helpful. I don't know if that's because of where I work in particular or if that can be applied on a wider scale. But they are very flexible with shifts, so – with moving shifts around. You can work on different days, for example.

MS ABRAMSON: Yes, see, one of the things we've observed is - it depends, obviously, on the nature of the mental illness – but one of the difficulties is the episodic nature of mental illness, at least from an employer perspective. That's why I was quite interested. The flexibility actually does matter quite a lot. Not all jobs, obviously, can be designed like that. But clearly if you've got flexibility, you can use it in a – and there's a good culture that sits behind it, you can use that to get, sort of, the days that you need to see your psychiatrist or seek treatment. So that's quite interesting to us.

MS RYAN: Yes, absolutely. Yes, absolutely, all the things you mentioned. Getting treatment - getting well in general – it does take time, so being able to take that time when you need it and being able to come back to work and not have to answer questions about it is another really big one.

MS ABRAMSON: So you've got - - -

MS RYAN: So to just be able to come back to work to be under the assumption that because you're there, you are well enough to work and they're happy to have you back, rather than sort of undermining you coming back is quite excellent.

MS ABRAMSON: No, it makes perfect sense, Trinity, because what you've really outlined is a number of conditions that are needed to be able to be in the workplace. And so that seems about leadership from the top of the organisation, which sounds like you have there, and also education for the staff, but then that has to be married with flexibility about how you do your job.

So I know I was focusing on the positive and you've brought our attention to the difficulties you've had in the past, but that was because we're looking to make recommendations that can help people in this situation, so that's why I was exploring that particular piece of your evidence.

MS RYAN: Yes, absolutely.

PROF KING: Without naming the former employer, as I understand you were with a retailer that is a large group; was the previous retailer that you were working with, were they also part of a large group, or was it a single, small store?

MS RYAN: They were kind of a large group as well, but it was a separate large group, different entity.

PROF KING: Yes, understand. Because obviously we're trying to work on carrots and sticks, incentives and where they can work for employers to create mentally healthy workplaces, and making sure things such as you mentioned, the mental health training for all the managers, occurs. In the previous organisation, that just didn't occur, from your knowledge, at least?

MS RYAN: No, there was nothing like that. I believe some managers were trained with a physical first-aid certificate, but there was no mental health training, very little knowledge within the workplace about it. And yes, a lot of stigma because of that.

PROF KING: Do you have any thoughts about, was it a cultural problem in the organisation, or was it just the one manager at the store level, or was it a bit of both?

MS RYAN: I believe it was cultural.

PROF KING: Okay.

MS RYAN: I did try and go higher-up, and yes, faced similar difficulties, I believe that ran through.

PROF KING: Okay. Just briefly, on a slightly different issue: you mentioned right at the beginning, you gave us your diagnosis; one of the things that we've had very mixed views back on from consumers is the issue of diagnosis. So I guess I'll put them into three groups: we've had some consumers who have said actually they would prefer not to have a diagnosis; they think once they get a diagnosis, they get pigeonholed, that it actually makes their recovery more difficult.

At the other end of the spectrum, we've had some consumers who have said, "Oh, and I got the diagnosis, thank goodness, because now I know what's wrong with me." And in between we've had consumers who have talked about the problems they've had with diagnosis, where they've had multiple diagnoses, it's been changed over time, and finally, they've got what appears to be a correct diagnosis but it's been a very traumatic period in their treatment.

So what was your experience there, and do you think a diagnosis is helpful, and how did you find that process?

MS RYAN: For me, having a diagnosis has always been helpful. It has changed over time what that diagnosis has been, whether it's schizophrenic with a mood component itself, and a mood component with depression. I think over time, the DSM actually changed that into schizoaffective.

PROF KING: Yes.

MS RYAN: But yes, having read the DSM-IV article on that, I'm quite happy with my diagnosis; I think it's correct. And I find it helpful in helping me know what to do about it; so when I do have those symptoms, I can put it down to that. Sometimes, I can find my way through it. And yes, I find the diagnosis helpful for me; I think for a lot of people they don't, but for me personally, it's helpful.

PROF KING: Just one final one from me. You mentioned low availability of psychiatrists and psychologists.

MS RYAN: Yes.

PROF KING: Issues of co-payment and bulk billing. In our draft recommendations, we talked about online, and for example, mind spots is an example for moderated online therapy, particularly for mild mental illness and mild anxiety, mild depression.

MS RYAN: Things requiring high-end medications, but it would concern me, the face-to-face interaction I feel is important; there's kind of no real way yet of replacing that, you can go with the internet and stuff. The other thing I would say is just would they be able to write prescriptions, then how would that work?

PROF KING: Usually, that would have to go back through a GP or something.

MS RYAN: Exactly, yes. So it becomes an extra step in a process for anyone seeing that psychiatrist online. I'd worry that more people may fall through the cracks in between that kind of seeing the psychiatrist, picking-up the medication from the chemist; it is an extra step and I know a lot of people do have difficulty staying on their medication at times.

PROF KING: Yes, I guess the thing we're grappling with is exactly that issue, that it can create extra steps, versus the exact problem that you mentioned, where we've met consumers who simply can't afford - - -

MS RYAN: Yes, I would say - - -

PROF KING: We're in Darwin at the moment and there's not too many psychologists or psychiatrists in the Top End.

MS RYAN: Yes, absolutely. So I'd say it's definitely worth looking at as an option, bringing in the Internet psychiatry, because then you can apply it to people that either don't

require the medication, or just simply don't have access at all, to other psychiatry and need that extra step, rather than driving a thousand miles or whatever. But in case that makes it easier or more possible, then it's obviously a good thing. But I think there is still value to the face-to-face connection.

PROF KING: Your view would be it's second best, but it's better than nothing.

MS RYAN: Yes, exactly.

MS ABRAMSON: Trinity, I wanted to ask you something that's not in your submission, but feel free not to answer it if you don't want to. One of the other issues that's been brought to our attention really is by the relatives and support people for the consumers, who've said that because of privacy laws, they've not been able to be told about a relative's condition; and we're thinking about this at the acute end, so a presentation to Emergency, and then the person being sent home to the family without them being able to understand what they can do to assist the person.

As Stephen said with another issue, we've had kind of mixed views; one of the views put to us is that properly explained, most consumers would give that consent. Not all, but most people would. And I wondered if you'd had experience of that, or you had a view about it? If you don't, that's absolutely fine.

MS RYAN: I was very down at first, first coping with my illness; it was before I was actually even diagnosed properly. But I did receive a lot of advice on confidentiality, privacy, I was told I didn't have to tell anyone; it was kind of very hidden from my family. And in retrospect, I think it would've helped a lot to have told them a lot more. I don't think - well, basically I think there would be a way, ways, around the privacy and confidentiality so not necessarily breaking anything private but something to be able to give the family and carers the information they need to look after someone. The access to the basics of the information that we have on that illness - - -

MS ABRAMSON: One of the things we've been thinking about is it's got like a legal name but it's an advanced care directive, and that would mean - it's used in other parts of the health system - that when you're well, and I understood the issue about being a young person, but when you're well you can say well this is actually the type of care I want and these are the people that I want informed about my situation. So that's one of the practical things we've been thinking about.

MS RYAN: I believe there are already advance care statements that exist.

MS ABRAMSON: Yes.

MS RYAN: I think the trouble with those is they're not used enough. Even I don't have one, and should, but there's often so many things that you think you might need in the time or you don't know but you can't predict what you're going to need or what you're going to want even when you're in that moment even when you're looking at it from a healthy

perspective.

MS ABRAMSON: No, I understand. Look, you've been very courageous in talking to us so thank you for that because it helps us make a difference for other people, so thank you so much.

MS RYAN: It's my pleasure.

PROF KING: Thank you very much, Trinity.

MS RYAN: Thank you, bye.

PROF KING: Bye. Next we have the Aboriginal Medical Services Alliance Northern Territory.

MS ABRAMSON: Who no doubt can give us some information about advanced care directives.

PROF KING: And whether clinicians pay any attention to them, which is one of the issues.

MS ABRAMSON: That's right.

PROF KING: If you could just introduce yourself and state your organisation and any introductory comments you would like to make for the transcript?

MR PATERSON: Sure. Thank you. So, chairman of the - - -

PROF KING: Stephen.

MS ABRAMSON: Stephen and Julie.

MR PATERSON: Are you sure, okay, cool, that's the way I like it, not all these formal titles and greetings. But let me say, let me introduce myself, John Paterson. I'm the chief executive of the Aboriginal Medical Services Alliance Northern Territory. I am also a member of the Aboriginal Peak Organisations of the Northern Territory, which is an alliance between the Northern Land Council, the Central Land Council, the Aboriginal Housing Northern Territory, and I'm also a territory representative from the Coalition of Peaks on the Joint Council of Closing the Gap. But I will be speaking today in my capacity as the AMSANT chief executive but I will make references - I would like to share some of the work that's going on nationally with the Close the Gap stuff.

PROF KING: Yes.

MS DYALL: Good afternoon, my name is Danielle Dyall, I am the social emotional wellbeing and trauma informed care manager for the Aboriginal Medical Services Alliance

Northern Territory.

MS BURGOYNE: And hi, I'm Daisy Burgoyne, I am service integration lead for mental health and suicide prevention, also work with AMSANT.

MS ABRAMSON: Thank you.

MR PATERSON: All right, well I will make a statement, read out the statement and then between myself, Danielle and Daisy we'll take and field any questions you might have of us. I would like to start by acknowledging the Larrakia people as the traditional owners of Darwin region where we meet here today and pay our respects to Larrakia elders past, present and future. I thank the Productivity Commission for the opportunity to attend and present at this hearing today.

The Aboriginal Medical Services of the Northern Territory, known as AMSANT, is the peak body of the Aboriginal community controlled primary health care sector in the Northern Territory. We have 25 members, member services, providing care to communities across the Northern Territory from Darwin to the most remote regions. Our services' comprehensive approach incorporates clinic care with social and emotional wellbeing, mental health, and alcohol and other drug services as well as family support and early childhood services delivered by multidisciplinary teams in a holistic service model.

AMSANT was very pleased to see the focus in the commission's report on the key social determinants including housing and homelessness. Contact with the justice system, income support, social participation and the impacts of racism and discrimination. Aboriginal communities here in the Northern Territory know all too well that socioeconomic context exerts a powerful influence on the distribution of health commissions and mental disorders through differential exposure, vulnerability, and access.

Public policies that focus on narrow measures of disease burden or economic productivity continue to position the mental health crisis within a biomedical, individualistic model. This inevitably leads to policy arrangements systems and services that drive unequal distribution of opportunity and creates ineffective and potential harmful outcomes. Here in the Northern Territory we see this reflected in the alarming numbers of Aboriginal people with poor mental health who find themselves on a trajectory to hospital, homelessness, and prison.

With our recent submission and our appearance here before the commission today we hope to demonstrate that there is another way forward, one which acknowledges the past and builds on the strengths that have kept Aboriginal people well for thousands of years. The Indigenous model of social and emotional wellbeing, otherwise known or referred to as SEWB, is holistic and integrated bringing together social and cultural supports with clinical care in a primary health care setting to support individuals, families, and communities, in all aspects of life that strengthen wellbeing.

The National Mental Health Commission's 2014 review of mental health programs and

services recommended that integrated mental health and social and emotional wellbeing teams should be established in all Aboriginal community controlled health services. Despite this our services are still often forced to contest for service delivery contracts for mental health services. Often these contracts are awarded to large mainstream NGOs who may have more capacity to present impressive grant applications but are often culturally inappropriate and lack relationships with the local communities.

Because of this our first and central recommendation to the commission is that Aboriginal community controlled health services should be recognised as the preferred providers of all mental health and social and emotional wellbeing services for Aboriginal and Torres Strait Islander people with adequate funding committed to fully realise the National Mental Health Commission's 2014 recommendation.

It is our view that the complete realisation of this recommendation will require at least the following; firstly, continuity of care for Aboriginal patients should be centred around Aboriginal community controlled health services as the link between government health services and hospitals, NGOs, community centres, outreach programs, and the local Aboriginal population.

We note in particular that this must include access to specialist child and adolescent mental health services which are effectively non-existent in many remote communities in the Northern Territory. This is deeply concerning given the high levels of trauma, mental health issues, and suicide that we see among our young people.

Secondly, we must improve connectivity between the different layers of the service system by creating sufficient pathways for access to community-led healing programs that are strength based and address the social determinants.

This requires dedicated funding to provide wraparound care through effective community-led mental health and wellbeing programs that facilitate regional service integration, case management and care coordination.

The early success of the Katherine Individual Support Program in reducing emergency department presentations and increasing access to primary health care demonstrates that this approach works and we refer you to page 6 of our submission for more information on that particular example.

And finally, we must build a stable and sustainable workforce made up of multidisciplinary, culturally and trauma informed teams with expertise across the various aspects of wellbeing for Aboriginal communities. Building this workforce locally through investment in traineeships, scholarships and mentoring schemes is essential.

Importantly, we would like to take the opportunity today to comment on the commission's recommendations to renovate or rebuild the approach to mental health funding in Australia. While there are some advantages to funds pooling, as suggested under the remodelling - the rebuild model, AMSANT is concerned that the proposed approach could see funding

that is currently directed from the Commonwealth to the Aboriginal Community Controlled Health Sector, filtered through the newly proposed regional commissioning agencies and put out for public tender.

Past experience has shown that when Aboriginal, alcohol and other drugs and social and emotional wellbeing funding became subject to increased competitive tendering under the Indigenous Advancement Strategy, there was a shift in service funding towards mainstream NGOs, in many cases leading to increased fragmentation and duplication of services. More than this, however; such a shift undermines community self-determination and the opportunity for local employment and capacity building.

Because of this, instead of blanket implementation of the rebuild model, we would like to see emotional - the social and emotional wellbeing funding currently held by the National Indigenous Australians Agency returned to the Indigenous Health Division in the Commonwealth Department of Health.

Then all Aboriginal-specific mental health, social and emotional wellbeing and suicide prevention funding should be funded direct from the Commonwealth Indigenous Health Division to the Aboriginal Community Controlled Health Sector.

Additionally, we would like to note our support for the commission's recommendation that indigenous organisations should be the preferred providers of local suicide prevention activities for Aboriginal people. In order to facilitate this recommendation, we'd also like to see a policy imperative that all indigenous suicide prevention funding that is currently going to mainstream organisations be redirected to Aboriginal organisations within the next five years or whenever their current funding agreements expire.

The commission's report suggests that governments need to make a choice as to how to tackle mental ill health in the long-term. Our suggestion goes further than that, to healing intergenerational trauma and dismantling systems that continue to oppress Aboriginal people. The long-term aim is that our health status matches the wider community. This can only be achieved through self-determination.

The commission's report states the limited control that Aboriginal and Torres Strait Islander have and feel that they have over the circumstances in which they live is seen by them as limiting both their social and emotional wellbeing and their ability to do anything about it.

In 2017 at the National Constitutional Convention, after months of consultation around the national, Aboriginal and Torres Strait Islander leaders came together and produced the Uluru Statement from the Heart, setting out an invitation to non-indigenous Australians to join with them in a process of truth-telling and political recognition of our First Nations people.

Our final call to the commission today is for you to acknowledge the importance of political recognition and truth-telling in improving the mental health and wellbeing of Aboriginal

people, with a recommendation in your final report that calls on the government to honour the Uluru Statement from the Heart. We'd be happy to take any questions. Thank you.

PROF KING: Thank you very much, doctor. Can I start by - I really want to explore the area of the Community Controlled Health organisations, the funding, so - are you familiar with the recent Victorian Royal Commission recommendation, by the way?

MR PATERSON: (Indistinct)

PROF KING: I can summarise it very briefly. So what they've recommended is that all Victorian mental health funding - and I'm going to get this slightly wrong because I don't have it on me, but all Victorian mental health funding for Aboriginal Australians in Victoria be directed through ACCHOs, where ACCHOs exist, and where they don't exist, there is a transition body. I know I've probably got the name wrong - - -

MS ABRAMSON: Yes, I'm just looking for the recommendation.

PROF KING: Yes. That will work with the community so that an ACCHO can be created.

MR PATERSON: Yes. Yes, yes.

PROF KING: So that the funding can be - so that's - so what I'd like to do is a sort of step up to that. So some people got back to us at draft when I asked the question, well, should funding go through ACCHOs? Their response was, well, ACCHOs don't exist everywhere, ACCHOs have different capabilities. It needs to be community controlled organisation that don't say ACCHOs. So we didn't. In our draft report, we - - -

MR PATERSON: Yes.

PROF KING: So was that right or - because now we're seeing the Victorian recommendation - yes, "Social and Emotional Wellbeing in Aboriginal Community Controlled Health Organisations". Yes. Now we've seen the Victorian recommendation which says Aboriginal Community Controlled Health Organisations and we say, well, did we go down the wrong path? Should we have been much more explicit and just said the exact same words as the Victorians?

MR PATERSON: Yes. We would totally agree with that, that reference. And the reason - and then that's the position of the AMSANT membership here in the Northern Territory. I can't speak for other jurisdictions, you know. Some will have a strong wish for it to go through the Aboriginal Community Controlled Health Sector.

In the Northern Territory, we have the commitment from the Commonwealth and territory governments that all Northern Territory remote clinics will transfer the responsibility of delivering comprehensive primary healthcare across to the Aboriginal Community Controlled Health Sector and I'd like to say, commissioner, where there's no existing health service, Aboriginal health service, then we will rebuild - we'll build one.

PROF KING: Yes.

MR PATERSON: Or where there's existing Northern Territory government-run clinics, then it's just a matter of, you know, establishing and getting an incorporated Aboriginal health board to then eventually take over the transfer and the transition of the responsibility of delivering the comprehensive primary healthcare and we've got a couple of regions in the Northern Territory where that currently is happening.

In the East Arnhem region, all clinics there now - they were previously run by the Northern Territory government. They have now transferred its responsibilities to the Miwatj Aboriginal Health Corporation there, so Miwatj is the sole governing responsible agency, service provider for delivering comprehensive primary healthcare in the East Arnhem.

And that's - look, I just want to refer and I understand we sent you through a couple of copies of the communiques from the Joint Council on Closing the Gap and you'll see there, there's four agreed priorities that's been agreed to by the Prime Minister, all the relevant first ministers in each state and territory, including our Chief Minister here in the Northern Territory, and I'd like to read that, because this is where we're getting that commitment now from a very, very high level of government, from the Prime Minister's office.

And it reads - number one priority - "Developing and strengthening structures to ensure the full involvement of Aboriginal and Torres Strait Islander peoples in shared decision making at the national, state and local and regional level and embedding their ownership, responsibility and expertise to close the gap.

Second priority, building the formal Aboriginal and Torres Strait Islander Community Controlled Services Sector to deliver Closing the Gap services and programs in agreed priority areas. And thirdly, ensuring all mainstream government agencies and institutions - that's governments and mainstream NGOs - undertake systematic and structural transformation to contribute to Closing the Gap.

And the fourth one was about the government funding us to the Coalition of Peaks \$1.5 million to build a data repository or a data portal, you know, at the push of a button which you'd be able to see what's happening in each community, you know, so that was basically that fourth - - -

MS ABRAMSON: And could I ask you about capacity building - - -

MR PATERSON: Sure.

MS ABRAMSON: - - - because we observe this everywhere, so for example we've been given evidence that some of the PA tend to do well, some not so well, and I know that when we've spoken to you previously that you do quite a lot of work around governance and supporting organisations, so I'm just interested in your organised views on that.

MR PATERSON: Sure. We're fortunate and lucky, I guess, here in the Northern Territory because AMSANT is a third shareholder of the Primary Health Network.

MS ABRAMSON: Yes.

MR PATERSON: So we've been there since the inception. You know, since those transitions of - I think prior to PHN I think they were Medicare locals or - - -

MS ABRAMSON: Yes, exactly.

MR PATERSON: Yes. They've had a few name changes and structural changes, but we've been an active member and now a third shareholder with the Northern Territory Department of Health and the mainstream GP services and their practice.

We've actually managed to influence the Northern Territory PHN in their commissioning framework that they have in there and they reflect the principles - the Aboriginal Peak Organisations has a set of principles when working between Aboriginal community controlled organisations and mainstream NGOs that there is a transition or a commitment to build capacity if there's no existing Aboriginal Community Controlled Organisation to deliver those services in particular areas, that the mainstream NGO will assist and support building or establishing an Aboriginal Community Controlled service provider, so eventually over the five years or whatever the term that they agree to in their negotiations, that the mainstream NGO will remove - withdraw from delivering the service.

They may still - there may still be a need there, but you know, because of the specialist care that may be required that the Aboriginal Community Controlled service provider may not have currently, but until such time as we build that capacity, there will be a need of those mainstream NGOs and other service providers to have some sort of involvement, but the leadership, the government structure, the goal setting, you know, the strategic planning, should be led by the Aboriginal leadership in the community or in the region or in the Northern Territory. You know, the Aboriginal peak organisations leading, you know, to close the gap and reform stuff at the national level.

PROF KING: Can I ask on exactly that, on that transition issue and that capacity building, one of the recommendations that has never seen the light of day from our human services report a few years ago was that all contracts to provide human services into indigenous communities had built into the contract a requirement to train up the local workforce to transfer the skills, the idea being that within one or two contract cycles you no longer had a contract, because you had the workforce there in the community.

How is that - I mean, I know that hasn't been accepted, but how is the work going with the NGOs? Are they working to build up that local capacity or are they sort of saying, well we're not made for that and, you know, how's that relationship going? Because if you don't build up the capacity - - -

MR PATERSON: Absolutely. Commissioner, you're spot on. And I was just at a meeting the other day talking about this very issue where some of the mainstream NGOs were saying that they aren't adequately financially resourced to build the Aboriginal Community Controlled capacity and resources there, so - and these are mainstream NGOs that are committed.

They want to make that transition to transfer the programs and services across to, you know, the capable Aboriginal Community Controlled Organisation, but they just don't have the funding, the extra funding to do it and you know, we would strongly recommend that - if you guys have got any influence in that space, we would strongly support and recommend that it be etched into your report somewhere that funders - you know, government funding agencies, consider that and make a commitment to it.

PROF KING: Just on some of the evidence that was put before us earlier this morning, so we discussed - we had a discussion about provision of services, for example, in the Barclay region and it was put to us it's important to have choice, so that all the money shouldn't be funnelled through, say, a community controlled organisation; it's important to have mainstream services side by side because even some Aboriginal people - - -

MR PATERSON: Yes. Yes.

PROF KING: - - - want the choice. Your response to that? Well, sorry, my response was well, is that practical, given the low population base? Can you actually financially viably have essentially parallel services? Your response to that? Is choice necessary? If choice is economically impossible - well, is it economically possible? If it's not economically possible, how is that dealt with?

MR PATERSON: I might add to that.

PROF KING: All right.

MS DYALL: I think that what we know from the evidence is that self-determination is one of the key things to being able to facilitate wellness and with community Controlled Health Services, like we said in our report, is that that's based around self-determination and around the community having control of the decision making.

And so when - so that's the position that we take. We do believe in partnership, though, and we do believe in the integration of services and that's how we work with comprehensive primary healthcare and if you look at the ACCHOs, then they'll have that integration of services internally, but also integration of services externally as well.

And we have to work that way to create that holistic wellbeing. However, with local decision making, that sits within a community controlled framework and that's our position, self-determination, which then leads to choice and control over their own wellbeing and health.

PROF KING: Any feedback on - sorry.

MR PATERSON: Sorry, commissioner, I might just - yes, just add to what Danielle's responded to. I think in some areas there just isn't any other service provider, so I think another option for those that choose that they don't want the services to be delivered by their local Aboriginal Community Service Provider is that that service provider is resourced so that perhaps they can contract out and that, you know, a service provider may not be available, like you say, in Tennant Creek, but it might be available from Alice Springs or Darwin, that can go and deliver the service that's been asked of them.

And this happens in the Aboriginal Legal Service. As you would appreciate, there's, you know, a court case with two indigenous - between two indigenous, you know, individual - the Aboriginal Legal Service can't represent both of them because of the conflict, so they have the capacity to outsource to mainstream legal providers to do the representation of the other person, so - - -

PROF KING: Yes, that's a really good - - -

MR PATERSON: A similar sort of model, yes. There's precedence already been set there. But we need to think through and get good arrangements, good agreements in place for the data, the medical records of those individuals. You know, because we don't want that disappearing from the local community either, because that person may, in an emergency, have to rock up to the Aboriginal Community Controlled Services Provider. If those notes or that information isn't available on their medical records, then, you know, the clinicians and others that are, you know, wanting to get a bit of a picture of what the last treatment entailed might find it a bit challenging. So you need to work out arrangements and processes about accessing that sort of information of an individual, you know, in those circumstances.

PROF KING: It's a problem Australia-wide. We don't join up Medicare (indistinct).

MR PATERSON: Providers.

PROF KING: Exactly.

MS ABRAMSON: I just had one question. I'm sure I read it in your submission, but if I didn't, I'm apologising. There were a few submissions. The community development program - so in our report, we looked quite hard at placement for people with mental ill health to get people into the workforce, and I seem to remember that there was something about there were a number of problems with the CDP and how it works for - in that mental health space. I might have got this wrong, but I'm interested in that.

MS BURGOYNE: Yes, absolutely. So I noticed in the report one of your recommendations is around evaluating the - under the Jobactive programs and, you know, the others the assessments for, you know, fit to work. But it wasn't mentioned that that should also be evaluated for CDP. So that was one of the recommendations - - -

MS ABRAMSON: We didn't know that. That's why I'm (indistinct) to talk to us.

MS BURGOYNE: - - - that you made – that we made to you, that it would be great to look at that as well because we have heard from CDP providers that those assessments are sometimes saying that people are fit to work when, you know, by all accounts, people who aren't – that they are inadequate, that – again, that they're sometimes not being carried out in a very culturally safe way. But I think even beyond, sort of, evaluation of those medical assessment processes, the CDP program in its current form – and there has been a lot of work done by Aboriginal peak organisations and a whole range of CDP providers over a range of years to push for a reform to try to make some really positive change and there have been a few, you know, positive changes. But overwhelmingly, in - the reports coming back from communities are that you see increasing numbers of people disengaging from receiving any kind of payment at all. I get it's this sort of – I guess that punitive sort of welfare model that's, you know, pushing people to, you know – instructing people what to do and how to live their lives rather than empowering people to do that themselves and there's also, again, big problems with the number of hours that are required of the participants, as opposed to Jobactive which was just highly unequal.

The nature of work sometimes – some CDP providers, they're doing fantastic, you know, really engaging work. At other times it's not providing people with a whole lot of, you know, meaningful work and engagement, and so – yes. What the reports are bringing back of communities is that you are seeing increasing numbers of people disengaging entirely and that is then also leading to less money overall in the community, and again, a lot of – some are things left over, but you know, the stress that that then puts on households in terms of food security, in terms of (indistinct) and those kind of things, potentially, you know, violence, you know, those – you know, these are the kind of things that people are talking about that this is having – you know, that this is the impact that this program is having on communities and without a doubt, that's impacting on people's mental health and wellbeing. So yes, it is a big problem. But there is the – what was the name of the – Fair Work and Strong Communities Remote Development Employment Scheme. So there's an alternative model that has been developed by all these CDP providers over a number of years. They've worked together to say 'how can we do this differently', and it being put to the Commonwealth – so yes, we've also recommended that you guys also support that as an alternative model.

MS ABRAMSON: Thank you. Thanks very much.

PROF KING: Just one final one from me – more curiosity because I was wondering, how's it all going in East Arnhem? Because - is that still in transition or is now – the (indistinct) has control of the relevant health services? Is the transition in – how's it going?

MR PATERSON: Yes, no, it's all completed. The last two were transferred, I think just prior to Christmas last year. The latter half of last year, anyway. Ramingining and Gapuwiyak I think were the last two, so all those clinics there that were former Northern Territory government-run clinics are now under Miwatj, a regional corporation, and - - -

PROF KING: Which is the next region off - - -

MR PATERSON: Red lane, there's the - - -

PROF KING: Yes. Sorry - - -

MR PATERSON: Yes, it's the newly – it's newly established. Well, it's been incorporated for a number of years now and – but just didn't attract any seed funding from funders – government funding agencies to provide the appropriate resources so we can (indistinct) the capacity of the new health service there. They've now got funding. They've got a transition manager, a business manager and a couple of field officers to go out and liaise now and explain to people on Minjilang and Warruwi, Gunbulanya, and it'll cover also the Cobourg Peninsula homelands, Kakadu homelands and Jabiru people living in Jabiru. So it will cover the western – what we call the western Arnhem Land region.

PROF KING: Very good.

MR PATERSON: And right in the middle on its own is the Maningrida, or Mala'la Aboriginal Health Corporation. We see that as a standalone regional health provider because there's over 3000-odd people there in the population, so it's big enough. It's got big, you know – it's – the economy to operate, rather than having to look at – across the – outside to partner up with somebody else. So the economy is of a scale of – to operate as a standalone health – they've got mental health and disability. They're one of our few Aboriginal community controlled health services that provides that as their own disability and aged care precinct, and then obviously we need to all those services, as much as they possibly can, to be on the homelands that are around that area.

PROF KING: That's fantastic.

MS ABRAMSON: I remember seeing something about the aged care because it was quite novel and unusual, so I actually remember seeing that.

MS DYALL: And they have a large Aboriginal work force. Quite a large one. It's really good.

PROF KING: That's fantastic.

MS DYALL: Really positive, yes.

MS ABRAMSON: Yes. Thank you very much.

MR PATERSON: Okay. Thank you, Commissioners.

PROF KING: And next, Sophie.

MS ABRAMSON: You've been waiting patiently.

MS MUNCH: Hi there, hello.

PROF KING: Sophie, if you could state your name and any body you represent or organisation you're representing, if any, and any introductory comments you'd like to make?

MS MUNCH: Okay. Thank you. My name is Sophie Munch. I've changed my name since I submitted that. So I am here on behalf of Saltbush Social Enterprises, where I am the manager of the low-intensity mental health program. So we employ over 65 per cent Aboriginal staff and we have a number of programs. I won't go into that. But my program, which is the low-intensity mental health – so I have a number of points to make. Some of them may or may not relate directly to my role at this organisation, but as a general observation of what the current system could improve on. So they may not be necessarily in the right order. I've just scribbled them up.

The first topic I want to talk about is the Better Access scheme that's not available for counsellors. I am sure this is not a new topic for you guys.

PROF KING: No.

MS ABRAMSON: No.

MS MUNCH: So for me, there are two – I can think of two areas. One is the plain inequity or injustice of the system, and here I actually want to share my own personal story. Between 2002 or 3 to 2007, I built up a very successful private practice in Brisbane, partly because I actually had a Bachelor of Clinical Hypnotherapy and I was a counsellor. So a lot of very difficult cases were referred to me. It's like I was the end-of-the-road therapy for a lot of these patients. So I had a lot of referrals from doctors and psychiatrists, and then when the Better Access Scheme came in, I didn't even notice it until a few years later. By about 2009, my business was more than halved. It was just so awful, and the doctors say to me, 'Sophie, I'm sorry, we can't refer any more to you'. Anyway, to cut a long story short, I had to close my business, and so that is the injustice side.

The second side is the productivity side, which is what this Commission is about. I'm – well, I'll publically state I'm 65 years of age. I've been a counsellor 22 years, so I entered the profession later in life, and I found that a lot of people that are counsellors actually enter the profession quite late in life and I think, you know, the life experiences definitely bring to bear. And it's like - the analogy I will give is if you have a 24 year old university graduate who study sex therapies and she's a virgin she would not be a very effective sex therapist, okay?

MS ABRAMSON: That's the first time that word has been on this transcript.

MS MUNCH: Okay, that's an extreme example of life experiences.

MS ABRAMSON: Yes, I understand.

MS MUNCH: Bringing to bear what the service is about. And within that productivity item I also want to talk about therapy or counselling is essentially an art informed by science. It is not a science. I actually was at a job many years ago where I had a treatment manual and I was told you have to follow the treatment manual but, wink, wink, do whatever you like, this is what the funding required.

Now, you cannot have a manualised treatment for clients and be effective and not lose the client, okay? So you can learn all the therapies under the sun, if you are a cold, blank faced, flat, you know, person that have no empathy you're not going to make it, you know. So that's why I think that to put - to afford certain disciplines the benefit of the Medicare rebate and other disciplines like counsellor not, perhaps - I don't even know what's the rationale, if the rationale was what they studied or didn't study then, that the art versus science will - that will take that down.

But certainly in any case a lot of the other disciplines that are given better access actually study less in counselling interventional skills. Now actually I was a clinical supervisor for a large organisation and I supervised all the psychologists, social workers, counsellors, support workers, across central Queensland, that was my job, mostly on the phone because it's remote.

And I had one psychologist that actually said to me, 'Sophie, I remember the first client that I had, she walked into the room, just sat down and bawled her eyes out and I sat there completely thinking oh, shit, what am I going to say, what am I going to say?' And she then told me that she only did two units in counselling, both of them electives. And yet she had better access and I didn't. Okay, so that's actually go back to actually the first one, I reversed it. That's my first item.

The second item is kind of related. Because of the better access a lot of jobs stipulate that they only looking for social workers and psychologists. And again, so personal experience, I was working in Western Australia and I was acting manager for 11 months and they kept not giving me the job until I - because they kept trying to talk to the powers that be because the job was funded not for a counsellor. I had already been in the job two years, I knew the community well, everything they agree that - anyway that's another story. So I think that instead of just looking at the better access the stipulation for the funded positions need also to be reviewed.

The next item is research actually consistently show that the best outcome for mental health patients would be psychotropic drugs along with therapy yet you see all the clients going to the doctor, they get antidepressants and that's the end of the story. So I just feel that whenever antidepressants and psychotropic drugs are dispensed they should also be referred to some kind of therapy counselling because no amount of chemical change in your brain is going to help you heal the past traumas, it's not going to help you with relational skills, communication skills, decision making skills, parenting skills, et cetera. So that's

another area that I feel quite passionate about.

Next item, I'm rushing. Okay, so the other thing is I've worked very remote, remote and very remote, I worked in Derby and I used to go up and down the Gibb River Road, in the wet season by small plane in the dry season by four wheel drive, and stay overnight and so on and so forth. So a lot of the - I think there is now that push, correct me if I'm wrong, I know eHealth is very big and eHealth is great, for physical problems.

For - you know, like I took nine months before I managed to establish relationships with any of those people, right, I used to sit with them under a tree and just simply yarn. And no therapy, right. And so I think I just hope, I don't know if that's been done, I hope that they're not going to push eHealth type therapy particularly for remote people. But even for non-remote.

Anyway, I don't agree with any web based therapy because even we know that motor neurons are triggered in the personal space, I don't think that any empathy or any - you know, the motor neurons are going to be fired through a screen. And particularly a lot of clients have these four inch little iPhone that their worker give to them, I actually do some remote work, which I just think it is sad that they don't get the kind of service.

Which brings me to the next point. I was actually working for Mala'la, the - I worked there for three years. So we used to have a lot of funding, almost people begging us to run programs, but we could not find staff. So there's two things, is capital investment, right. So I will talk about staff accommodation. We could not employ staff because we had no capital structure and no one funded that, or we couldn't find funding to build accommodation.

And I actually left that job very sadly because I really got burnt out, I was just, you know, me, myself and I, and then later on we found one person who did not require housing because her partner was already in community. That was how hard it was, you know, so that's another area that's outside of this mental health productivity but it's related, is the capital funding.

Even now where I'm working, Saltbush, a great organisation, you know, like - but we don't have a building, I have to do outreach. When you got to a client's house, they've got dogs running around, 10 people in the house and the kids keep coming out, you sit outside and it's really hot in the heat, it's not conducive. We don't have a counselling room because we do not - we're just using the premises that is for another program where I'm housed.

So it just feels that there's this need, there's a great organisation that's really run by a lot, 65 per cent, Aboriginal people for Aboriginal people and yet we don't have the capital structure. So other thing is the same in remote community, is the housing. You know, like Health in all Policies as far as I'm concerned. It's a well health organisation initiative and I think South Australia is the only state that subscribes to what they call Health in all Policies.

Health in all Policies means that they look at how from the very top of the government - they don't look at how just by the health minister but they talk, the departments talk, so housing, education, so on and so forth. A lot of the remote Indigenous communities their disadvantage, or their mental health issues, so totally related to other areas like housing. Housing wait in Maningrida was eight to 10 years.

Meanwhile 17 people lived in a three bedroom house. I mean, I would be fighting - I would have domestic violence if I have to live with 16 other people sharing one toilet. Do you know what I mean? So that's probably outside the scope of this commission's hearing but I think somehow somewhere it can be fed back and take South Australia as maybe an example, I don't know how well or not well they're doing but I know they are the only state, yes. I think that's all I've got from my - - -

MS ABRAMSON: That's quite a lot, actually, Sophie, thank you.

PROF KING: Workforce issues, so you said, you know, the issue of accommodation meant you couldn't employ staff, you were concerned about eHealth - - -

MS MUNCH: Not having that personal connection.

PROF KING: Yes, but then we've also heard evidence about just the workforce issues, particularly in the Northern Territory, they've just started up counsellors and psychologists and psychiatrists, so how do we balance - firstly let me ask a concrete or a more narrow question, if the choice may be between no service or a distant service which may be video based or eHealth?

MS MUNCH: Yes. Well I can actually say that it's almost a waste of money, a waste of time. I have been seeing one person from Wadeye, so our service actually - I just don't feel like first of all that - I just don't feel really connected, and then after three, four sessions now he - the worker couldn't find him and she said, 'Look we've been wasting your time booking the appointment and him not showing up and we're going to have to talk with him, how come isn't he -', and I know that if there was that service or that location, Wadeye, had on the ground counsellors they would be able to engage that person much better than being here in Darwin.

So I hear what you say and what's the choice, I think it's probably better than nothing but if you look at productivity it's probably very close to not much. I don't want to say nothing because for sustainable change, see, I think that therapy shouldn't be, oh, I really felt good, I talked to the therapist today, it should be sustainable because otherwise I become - they become dependent on me and I become facilitator of their continued dysfunction, whereas there should be sustainable change. So that kind of thing cannot happen.

PROF KING: How much - yes, because with workforce shortages it can be very difficult living in communities for outsiders, how much do we depend for progress on local people being trained up to be counsellors and so on, is that one way to try and answer the - - -

MS MUNCH: Well, yes and no, the theory, in theory, yes, but in practice probably not. And the reason is because a lot of the very disadvantaged people in very remote places they have multiple very complex trauma, they have very high complex needs, to have the kind of counsellor that will actually be able to help them make a difference, a sustainable difference, you likely looking at someone that's, you know, gone through a lot of training, been trained in multiple models of therapy and so on and so forth.

I'm not saying that the local person is not capable of doing that but in order for them to actually attend university, it's just a very long process and it's like if you're stuck in that disadvantage it's harder to break out of that and actually accelerate and excel, you know. So for them to - but I absolutely am passionate about empowering local people in any capacity, meet them where they're at and develop them where they're - and that's all about community development, right?

PROF KING: Yes.

MS MUNCH: But to get to that level will probably take a very long time.

PROF KING: It's a long process.

MS MUNCH: Yes.

MS ABRAMSON: Thank you so much.

MS MUNCH: Thank you.

PROF KING: The next one is Gally McKenzie. Gally, would you be able to state your name and organisation and any introductory comments that you would like for the transcript?

MS MCKENZIE: Of course, Stephen. I'm just going to put my phone on the loudspeaker so just bear with me.

PROF KING: Of course.

MS MCKENZIE: Can you hear me?

MS ABRAMSON: We can.

PROF KING: Yes, that's fine.

MS MCKENZIE: Thank you. So I'm Gally McKenzie, I'm talking with you today. I'm the chairperson of the Australian Association for Infant Mental Health. We are a national association and we have branches in every state and territory with one developing at the moment in the Northern Territory. We have I think about 430 members which comprise of health professionals in the main and early education people, policy makers, yes,

comprise, and I think - what else would you like to know?

We're a company limited by guarantee, we're not for profit, we're run by a board of directors and an executive who are all senior infant mental health practitioners who volunteer their time, expertise and resources to AAIMH. And each branch, that is the state and territory branch, also has a management committee who likewise their members volunteer their time and expertise and resources.

And we're each with the Awards Association at Torrington Mental Health. Yes, and just as an aside, there were (indistinct) conference for (indistinct) mental health is actually happening in June this year, and it's called Creating Stories in Interim Mental Health Research, Recovery and Regeneration. It would have all the nine (indistinct) and many hundreds of committed practitioners from a practice at Gove.

How about I just give you a little line about what infant mental health refers to?

PROF KING: Yes, that's fine.

MS MCKENZIE: Okay. So it's the developing capacity of the infant and young child - that is from pregnancy to three years old - to experience, express and regulate emotions from close and secure relationships, and explore the environment and learn, all in the context of the care giving environment that includes family, community and cultural expectations.

Because infant mental health may be defined as a multidisciplinary approaches to enhancing the social and emotional competence of infants in the biological relationship and cultural context. It requires expertise and conceptualisation from a variety of different disciplines and perspectives, including from research into the good practice and public policy.

And our mission is to help give infants, young children and their families, the best possible start in the important early years of life, by improving professional and community understanding that infancy is a critical time for the development of emotional, physical, cognitive, social and mental health.

So, that's the context from which I come to speak with you. I'm a clinician, I'm a psychotherapist, and have been a clinician for over 40 years.

PROF KING: Okay. You've shot through some notes, so thank you for those. Now, you've got some comments on a number of our draft recommendations; I wonder if you'd like to just briefly run through those comments, particularly obviously the ones relating to child and adolescent mental health?

MS MCKENZIE: Thank you, yes. First of all, I congratulate both of you and your colleagues and your team; your draft report is really extensive and inclusive, so that's been

really rich to read that and note that approach. I will comment on one of the fact sheets on children, childhood, children and young people, which states that:

Early identification of risks in children and young people enables intervention and prevention of mental illness.

With which we agree. This can significantly improve mental health, and social and economic outcomes. It says:

For many children, pre-school or school is the place where risk factors for social and emotional development are quickly identified.

However, AIM would like to argue that infant mental health-oriented maternal and child health nurses are more than aware of mental health challenges, if not disorders, in the infants and/or the parents that attend their clinics, or are seen at home visits.

The potential to improve mental health or allay the worsening of challenges exists for infants in child health clinics throughout the country. Therein, AIM recommends early identification, not only by maternal and child health nurses, but also by midwives and general practitioners, who are aware of infants at risk of developing mental health challenges from their earliest days.

And so to that, we have additions to the existing draft recommendations.

PROF KING: Yes, please.

MS MCKENZIE: So for draft recommendation 8.2, Child and Adolescent Mental Health, and we recommend a long-term commitment to the provision of hospital-based and specific mother/baby-based known in the kids ward as the MBU, in all states and territories as a priority. I will speak to that some more.

So this also links with draft recommendation 13.3, Family Focus and Carer-Inclusive Practice. "There is no such thing as a baby," John Wintercock, who was a British paediatrician and psychoanalyst, said:

Alone with a baby alone doesn't exist. What exists is always a nursing couple. A baby trusts someone to take care of him or her.

He also introduced to us the concept of a holding environment; in other words, infant wellbeing is contingent on their carer or carers' wellbeing. AIM recommends family-focused and carer-inclusive practice, including, as I mentioned, mother/parent, baby or toddler units in all states and territories to preserve and enhance secure attachment relationships as the bedrock for infant mental wellbeing.

PROF KING: Yes.

MS MCKENZIE: So for draft recommendation 11.1, the National Mental Health Workforce Strategy, we would like to add, AIM recommends that the Workforce Development Program, which is being undertaken for the National Mental Health and Suicide Prevention Plan include consideration of our youngest and most vulnerable persons. The infant idea is yet to be born infant, in other words, it is unusual today.

I have included in my written notes a section from the UK House of Commons Health and Social Care Committee. You've got that?

PROF KING: Yes, we've got that, yes.

MS MCKENZIE: Right, so I don't need to go through it?

PROF KING: No, no, that's fine, we've got that.

MS MCKENZIE: Thank you. Okay, so I went through some more of what you've collected as recommendations. For draft recommendation 11.2 Increase the Number of Psychiatrists; AIM recommends specialist infant mental health-trained psychiatrists be available in all, and especially in the non-metro areas.

For draft recommendation 11.3 More Specialist Mental Health Nurses. AIM recommends specialists infant mental health training, and regular, consistent, reflective supervision be available for mental health nurses in all areas, and especially in non-metro areas.

For draft recommendation 11.5 Improve Mental Health Training for Doctors, AIM recommends clinical infant mental health training and consistent, regular, reflective supervision for doctors be available in all, and especially in the non-metro areas.

For draft recommendation 11.7, Attracting a Rural Health Workforce, AIM recommends the inclusion of consistent, regular, frequent, reliable, reflective supervision, not only as a workforce development strategy, but as a workforce retention strategy.

PROF KING: Yes.

MS MCKENZIE: And now I move to the finding 16.1, Prevention and Early Intervention to Reduce Contact With the Criminal Justice System, and finding 16.4, Health Partnerships; AIM recommends that the Family Court Judiciary are asked to ensure they gain a basic understanding of the importance of decision-making appropriate for infants and very young children, and why this age would be different even from children three years and older.

The Family Court Practice and Procedures, The Rights of the Child To Be Heard, in 2010, recommended the Family Court should consider implementing a training program for judges, and with state and territory agreements, magistrates exercising Federal Family jurisdiction, a more inquisitorial approach to determining the best interests of the child. AIM strongly supports that recommendation, and that such training be on the latest knowledge of infancy, the impact of environment and type of caring relationship.

Good infant mental health and wellbeing is the prevention of later social mental health, intergenerational economic and justice problems in adults, and in adolescence.

With draft recommendation 17.1, around Pre-Natal Mental Health, AIM concurs with the recommendation.

For recommendation 17.2 and 17.3, Social and Emotional Development in Preschool Children and Social and Emotional Development Programs in the education system, AIM recommends the inclusion of ages zero to five (indistinct) be used, as preschool is often interpreted to mean the immediate years before formal schooling. AIM recommends that (indistinct) professional development for workers and professionals that consistent, regular, and reliable, reflective supervision be integrated into the broad workforce, that is, the clinical and non-clinical workforce - for example, early childhood educators and teachers who work with infants in the zero- to five-year age bracket – as a means of ensuring best practice and accountability.

PROF KING: Yes. Gally, can I get you there – just to ask you on that one, we’ve received significant pushback on considering emotional threshold – emotional development in preschool or in zero- to five-year-old children, and there is a view from certain sectors that that will lead to over-medication of children, that it will lead to abuse by GPs and pharmaceutical companies. Do you have concerns in that area? Should we have concerns in that area? What safeguards do you think would be needed in that area to make sure that children who – and families, because it’s really – zero to five, it’s really families in need of support – how do we make a clearer – how do we create the safeguards for that type of recommendation, or those sets of recommendations?

MS MCKENZIE: For sure. Well, AAIMH together with the World Association (indistinct) the use of the DC: 0-5, which is the diagnostic classification for infants from age zero to five. So that is a diagnostic classification manual which clearly articulates the various presentations, I guess, that would concern clinicians. It also includes recommendations as to treatments and certainly medication or any form of treatment that is not relationally based is not the preferred option for this age group. So I think with ever season, there is – yes, no, I don’t think it, I know it. There is concern in particular around children who might exhibit what is called attention deficit hyperactivity disorder or autism or the various presentations that are kind of grouped under those headings. Infant mental health has a very different perspective on some of these presentations. The main thrust of infant mental health work is around relational work. It’s around the attachment between the little one and his or her primary carers as a vehicle for treatment. So in other words, AAIMH’s preference and its main modality for working is actually in a relational way, rather than a, you know, pharmacology or even behaviourally-oriented interventions.

PROF KING: Any thoughts on how we make that – because in a sense, that’s also what we were thinking, that it’s relational-based. Any thoughts on how we make that clearer in our recommendation or in the text, or – because of – I mean, we have received more submissions post-draft against social and emotional wellbeing checks for zero and five – to five-year-olds than any other issue.

MS MCKENZIE: Interesting. I'm glad to hear people are concerned for little people though. Okay, well, perhaps some documentation that might be worthwhile for you guys is the AAIMH competency guidelines for culturally sensitive relationship-focused practice promoting infant mental health. We call them – we just call them the competency guidelines. So Stephen and your colleague, the space infant mental health is, as I mentioned earlier, an interdisciplinary field and we work together in teams to work with little people and their families. So in that, we have now got a set of competency guidelines that is – that are relevant to all workers that work with infants, and that's whether they're psychiatrists, GPs, whether they're early childhood people – nurses, doctors, speechies, occupational therapists et cetera – and what we recommend is that workers who work in this field be able to demonstrate that they are actually endorsed to work in the field. So in other words, that they have undertaken and meet the competency required to work in the field. Yes, so processes are currently underway here in Western Australia – we will be the first state, or the first place outside the USA to actually be able to endorse infant mental health practitioners. In other words, to accredit them to work in the field. Yes. I don't know if that's of any help to you at the moment.

PROF KING: Yes, no, that's good.

MS MCKENZIE: Yes.

PROF KING: Okay, thank you. Sorry, I interrupted your flow there.

MS MCKENZIE: Please interrupt me, that's fine. I think, in fact, I've covered maybe – probably most of it, at least what I've written down here. We talked about the (indistinct), so I've mentioned the DC: 0-5, the manual or the training – sorry, the diagnostic manual, yes. With regards to 21.1, the cost of suicide and non-fatal suicide attempts is high, we would recommend consideration of the UK report, the one I mentioned earlier that I think you guys are very familiar with. But I'd just like to draw attention to a line – a couple of lines in this which indicate that individuals with four or more adverse childhood experiences, which are known as ACEs, are at a much greater risk of poor health outcomes compared to individuals with no ACEs. They are also 30 times more likely to attempt suicide, and the UK report recommends - intervening more actively in the first 1000 days of a child's life can improve children's health development and life chances and make society fairer and more prosperous.

PROF KING: Okay.

MS MCKENZIE: It also, of course, speaks to social stresses, which of course impact children's and families' wellbeing. Okay, so there's one other point I have here. With regard to government responsibilities and consumer participation, (indistinct) to inject genuine accountability for system outcomes to clarify responsibilities for program funding and delivery and to ensure consumers and carers participate fully in the design of policies and programs that affect their life. So this might actually link to what you raised earlier with regard to people's concerns about little people being medicated. AAIMH recommends

that scope of practice is clearly articulated, appreciated and supported by all professional workers, educators and employers working within the infant mental health field. I think you will well know that there are practitioners or workers who are tasked with working in non-government agencies, perhaps in rural and remote locations, who are faced with enormous responsibilities and safety issues with regards to children and their families. But these workers and these agencies are not always adequately equipped to deal with the complexities.

So we're concerned that workers who work in these arenas be adequately supported to appreciate always the boundary of their practice and that the agencies also be aware of the boundary of what is possible, and that channels be opened for these agencies to be heard with regard to their concerns – but not just heard, but that action be taken to support the families via supporting the workers in these agencies in order that workers themselves feel safe in their work or/and in their workplace, and thus can offer safety for infants and families in their communities.

PROF KING: Okay. Thank you very much for that, Gally.

MS ABRAMSON: Thank you.

PROF KING: Thank you for your time today. That's been really useful and helpful.

MS ABRAMSON: Thank you very much.

MS MCKENZIE: Thanks for your buzz and thanks for all your great work.

PROF KING: Okay, and last but not least, Anne. Anne, if you would be able to state your name, the organisation you're representing and any opening comments you'd like to make them in the transcript.

MS GAWEN: Hi, my name is Anne Gawen and I'm the CEO of TeamHEALTH. I would like to acknowledge that we meet today on the lands of the Larrakia People and I would like to acknowledge the elders past, present and emerging.

So I'm the CEO of TeamHEALTH and we're a non-faith based mental health organisation. We believe the largest in the Northern Territory mainstream organisation. And our focus is on psychosocial supports for Territorians. We provide services and support to Territorians who have a mental illness or who are vulnerable and disadvantaged and have fallen through the cracks. And we've been doing so for 30 years.

What this actually looks like is supporting people when they come out of hospital or when they become unwell to regain confidence and connections. It's gaining safe and secure housing, getting a job, gaining skills, or whatever it is in their journey they want to achieve. It's listening to and understanding what an individual wants, utilising their strengths through using outcome stars and other tools and helping them create their best life. What we acknowledge is that a valued life looks very different from everyone.

So I'm thinking you guys have had a pretty long day and much of what you've heard is probably what I'm going to say so I'd like to just talk from my perspective as a new person up in the Northern Territory and some of the experiences I've had up here. And also my experiences in working in the NGO sector as a leader for over 25 years and how that translates to up here.

I guess the four key things I want to talk about is it really is different here and I'd like to talk about that a little bit more. Secondly, that focus on psychosocial supports. We keep hearing it, the Productivity Commission has clearly said the problems and solutions like beyond the clinical areas yet what exactly does it look like, and I feel that the commission's report maybe didn't engulf that enough. And you actually said that last week.

MS ABRAMSON: Yes.

MS GAWEN: So what does that actually mean? I'd also like to talk about the absolute need for accommodation and what TeamHEALTH are doing in that area and what - after the conference last week where I saw you I feel like we're doing really well and I'd like to share that experience. Also I'd just like to talk a little bit about our partnerships with some of the Aboriginal controlled organisations, I haven't put that in our submission but I just thought from - - -

MS ABRAMSON: Absolutely.

MS GAWEN: - - - what I've heard today you might find that interesting.

MS ABRAMSON: Yes.

MS GAWEN: Remembering that I'm talking as a person who has been here for five months, and so I'm by no means an expert in any of those things. I'd just like to start with the territory's difference. As soon as we say that people's eyes glaze over. It really is different. I've been working here for a long time and I've heard many, many stories. I guess I'd like to give you an example of how different it is, so we run programs out at Gunbalanya, so you've heard that mentioned a few times, so that's about 80 kilometres across Cahills crossing, the most notorious crossing in the NT, I think, that's what people tell me. And an Aboriginal community out there and we have four Aboriginal staff that run that service, that's funded by DSS and it's a wonderful service.

When I went out there to visit the Aboriginal staff and my air conditioner broke down, but that's another story, they were talking to me about the work that they do. A wonderfully funded program by DSS I have to say. But one of the stories they told me of was that with an Aboriginal boy, a young man about 15, 16, and he simply would not leave his room, his house. And so after they'd worked with the family for a long time and they talked to him they finally convinced the family get an assessment from the Top End Mental Health Service.

And so they met the lady enthusiastically, she then came to the house, she was a white woman with purple hair and earrings. Like that's okay, but it wasn't okay for the family. And so the family sent her away and that was it. So basically our staff just worked with this boy one on one every day, half an hour, an hour, showing him somebody cares, there's a focus. The outcome from that was he eventually returned to school, he eventually gained support in Darwin. He's now two years down the track he's come out as a bisexual man who is functioning out at Nhulunbuy.

So a successful story that to me made my heart sing, like that's what the difference is about. And they have a myriad of stories like that, that's just one. You know, we were there after school, we were sitting in the room, 30 children were there and they said, you know, 'Anne we can't go out and say we're here to talk to you about your child's mental health concerns or your mental health concerns', what they do is they run programs after school, safe programs, and when parents come in they say, 'Do you want to have a chat?' You know, 'What's happening with you?'

And they do that very informal but really supportive program. One of the things they were doing was working with a child who needs monthly injections, and I can't remember the illness, but if he doesn't get it he'll die, and so their focus is around talking to the family about the importance of that. Taking them to the shops, talking with the mother, the child, sorting out the school, he'll be away from school, all of that, you know, really practical things.

And this program is flagged with DSS for its lack of reporting. So there's an alert, apparently. So, you know, as a new person in TeamHEALTH, you know, in other states I'd go I don't care, get the stats, I can't say that here. So we spoke and we spoke and we spoke and in the end talking to the local staff and our Katherine team we decided that we would send a Katherine team up, two staff, one Aboriginal and one non Aboriginal, to simply just sit with them for two days and get the stats in. Great.

Four times they attempted to get out there; the first time they were half way there, so it's sort of a 300 kilometre journey from Katherine, the first time there were five deaths in the community out there in one car accident that the community was shut down for two weeks; the second time there was another death, the community was shut down again; the third time they'd actually got to Jabiru, it was the wet season so you have to fly from Jabiru into Gunbalanya and the winds were too bad the planes couldn't take off they had to go back to Katherine.

So we missed the reporting deadline and we're still flagged. I've never experienced that before, I've always thought there's an answer, there's a way you can get this stuff. So the cost of that to us as an organisation, you know, three times getting people out there, flying them across, two people then leave the Katherine office. So to me that's the difference, I've not had to experience that as a CEO before. And the cost of that, it's hard to actually show what it is but it's significant.

So when you hear about, gee the NT is different, 75 per cent dirt roads, really remote

communities, that's what it means. It means we have to rethink the way we do things. And does that mean that, you know, we have to support those Aboriginal staff but they just said, 'We don't want to do stats, it's not our thing, we just want to work with people', so how do you manage that? I guess that's the challenges and the complexities for me in the NT and that's where we need a little bit of support. But I can imagine in Canberra DSS stats they look at Gunbalanya, what? No way, you know, they don't have enough people.

PROF KING: So is one way of getting around the - so, I think you were here for the earlier discussions about the money going through the ACCHOs, is one of the ways to get around what is a program by programs of democracy in Canberra is to say well the money starts with the ACCHOs and then they can make decisions about services and so on but it's a local responsibility rather than a Canberra responsibility?

MS GAWEN: I don't think so. But I don't actually - I'm not an expert. What I can tell you is that we have a relationship with Mala'la, who is the Maningrida organisation, so we offer psycho/social supports with them. And we talk to them a lot about how we do that and how they're supporting us and they have simply said, 'We are at capacity, we can't do any more', but the PHN want this program to happen so we actually give them a percentage of our funding to give us some cultural competency support, some reputation support, and they pick us up from the airport, our staff, and they give us cars and an office space.

And we talk to them monthly about what's happening in the community and where things are at. So to me that's a really successful partnership. But they're a fairly developed organisation in that they've been operating for a long time and they understand when they're at capacity and they've asked us to help. The other partnership that we're working within is in Katherine, so if I jump to another topic?

PROF KING: Please.

MS GAWEN: The supported accommodation is just absolutely critical and I love the model we have up here, which I will talk about later, but a report that I've got about the gaps in Katherine in the mental health services are supported accommodation. And nobody has been able to fill that gap. Well that's what we do and we do it well. So we've actually been asked by an Aboriginal controlled organisation would we consider working with them to set that up. And I said, 'I can get you the money and I'll make sure we get the money, let's do it together'.

But I think what it means, let's do it together, is let's actually do it together, let's not you sign an MOU to say we support each other and then it goes in the drawer and you never see it again, we're actually going to we're now developing a budget where they will staff some of it, we will staff some of it, we'll offer the mental health expertise, they will give us some of their accommodation, offer the cultural competency, give us some Aboriginal staff because we don't have enough down there.

So to me that's a true partnership. And we're doing it together so I don't know who is in control of it. We'll actually have a look at, well, who's contributing the most and let's do it

together, let's do a true partnership. And to me that's the way of the future. And together we are working with the Aboriginal health organisations down there, and I've met with all of them so far and said, 'Is this something that you want?'

And absolutely, they've all told me, 'We could give you 10 people tomorrow to go into that supported accommodation, just set it up, we don't care who runs it, just set it up'. But, you know, 'Do it in a way that the community are going to accept it'. So our partnership, we would never do it on our own in Katherine.

MS ABRAMSON: So, Anne, is part of that model there that you're also building training competency amongst the workforce there? So if the other organisation has some people who would like to work in housing, for example, but they need to be trained, is that something that you're supporting?

MS GAWEN: Yes, look, that's something we're looking at and we're in the partnership with the mental health expertise and they're in the partnership for their Aboriginal competency and understanding of the culture. And it's actually a drug and alcohol service, is what they do as well. So will talk about how we can share our staff because it will just increase both of our capacities, which is really important down there.

MS ABRAMSON: Yes.

MS GAWEN: And then we'll look at some mental health and community services pathways. And they will look at other pathways for us. So no one is stronger or helping the other one, you know, this NGO is going to help the ACCHOs, we're helping each other and it's actually about us working together to get the outcome for the community. So for me from an outsider it's about what best partnership works rather than having these hard and fast rules about this money can only go to this person and this money can only go to this person.

MS ABRAMSON: So if you thought of that from a big design point of view, which is where we come from, what does the funding model on the ground look like to enable you to run that model without having to reapply every 12 months and the funding is in that bucket and you're cobbled together all the buckets, so what would it look like?

MS GAWEN: Yes, that's what I'm doing. It would look like a big picture model where needs are identified which it clearly is there, and where tenders go out that identify the needs and where partnerships are necessary to achieve - I'm not answering the question very well, I'm sorry.

MS ABRAMSON: Yes, no, I know what you're saying, what you're really saying to us is if you want to provide those services on the ground get the funding to what we're trying to provide, don't think of it in terms of housing is only a small component, mental health is only a small component. I think you're encouraging us, correct me if I'm wrong, to think about well what is the service overall that's been provided, pool the money for whatever set of work and then ask the people to deliver. And be evaluated - - -

MS GAWEN: Absolutely. And in this situation we're driving this, the two organisations are driving this from a Gap report.

MS ABRAMSON: Yes.

MS GAWEN: And one of the lovely things up here, and I'm not happy to go onto the record, is the NTG, are responsive, you know, even though there's a lot of press about their economic state, like they actually want to do the best for the organisation so I think that shift around we're all in this together, this is a really critical gap, and I've actually just met with the minister this morning, this is a critical gap, we're going to do it, who is going to fund it, like we have to make it happen, and we can show you the business case to make that work. And to me that's something that is a great thing about the NT, I feel like we'll get it, I think we - - -

MS ABRAMSON: It's more flexible.

MS GAWEN: It's more flexible, yes. And I guess there's trust in the NGOs that they can do what they need to but also, you know, in partnership with an Aboriginal controlled organisation, which is critical. So those partnerships are really critical. If I talk about our supported accommodation, our partnership in Darwin is with the Top End Mental Health Service and we actually have a great relationship with them.

MS ABRAMSON: And I'm assuming that that is for - it's not just for Aboriginal Australians, that supported accommodation?

MS GAWEN: No.

MS ABRAMSON: That's for everybody?

MS GAWEN: So that's for everybody, yes. So we have about 48 per cent of our participants in that are Aboriginal people. Others are 25 per cent core people and then - you know, diversity. So that is a great model and the reason, you know, thinking about last week why it's such a great model, is it's a great model because of its flexibility. So we - I'm sure you've read in our response, that we built a \$5m facility - it's not a facility, accommodation services, with the help of the Federal Government a couple of years ago and it was opened a year ago and we're just transitioning people in it and everybody is excited about our option.

But as we've been transitioning people in it we had five spare rooms when there was news reports plastered across the NT News that there was a massive critical shortage in beds in hospitals. So went to the NTG and I said, 'It's not okay, we have these rooms, let's talk about what can happen with them rather than we sit there with our pristine rooms with nobody in them while we're transitioning across'. So the NTG were really great and we set up an interim model that relaxed some of those eligibility issues that are plaguing this sector, I think, about someone can only come in if they have a case manager, if they're not

drug dependent, if they have this and this, and it just stops people from getting well.

So the model was about there are some people that need to be in hospital but there are others who were not happy to say yes they're okay to go to community but they don't need to be in hospital, so we're taking a lot of those people and it's working really well because they're getting that step down supported accommodation. It's usually just for short term and it's usually just they need help to get a few bits and pieces sorted.

MS ABRAMSON: And so what does the supported accommodation look like, you've got somebody on site 24/7?

MS GAWEN: Yes, 24/7, so there's somebody on site 24/7, and each person has a focus on their recovery goals and what they want to achieve and for some people it's very simple and for other people it's a really extensive recovery model. And then the other lovely thing about our model is the NTG fund, Department of Health fund a recovery assistance program for us so we tap that into the accommodation service. So as soon as somebody goes in, when they're ready, they then get a recovery assistance worker who can work with them about whatever it is that they want to achieve but long term if that's what they need, which to me is the essence of non-clinical support.

MS ABRAMSON: You've got one - which is a wonderful initiative, you've got one of these models, but I imagine there's a huge need and that's just tapping the surface?

MS GAWEN: There's a huge need. And we're very successful in Darwin because we have the supported accommodation and three different models in that, we also have community housing, we also have other housing stock that we can use, we then have the recovery assistance model, we then have our Child and Family Early Intervention if that's needed. So a wonderful supported model, we work with Top End Mental Health Service extensively around that, if things get acute we have processes around that, so we're not relying on psychiatrists who see them once a fortnight but we do all the work in between.

You know, we have psychologists that operate independently out of our premises if that's needed. But usually we're finding that people just want an ear, they want to talk, they want someone who understands so we try and - we have a high proportion of people with lived experience in our staffing teams, because that's what to me is, you know, what was talked about in the Victorian Royal Commission, they kept referring to the middle ground. You know, where's the middle ground? That's the middle ground to me, it's that support working through your journey with someone to focus on recovery. And then if they have a severe and consistent mental illness we then refer to the NDIS.

MS ABRAMSON: Yes, I was about to ask you where that line was that – yes.

MS GAWEN: So to me, the NDIS is an absolutely wonderful scheme for severe and persistent people with mental health issues, not somebody who presents at hospital that just maybe needs a bit of help to get on track, you know, and that's what I was explaining to minister files today. I fear that there's this thinking that 'oh well, the NDIS is going to take

away our responsibility to the mental health sector', and I think we'll see in Victoria that that's what happened, and it's just not. It's simply not, and particularly in the NT with such complexity. So I guess my mantra is really urging me into government. It's not the answer – the NDIS is not the answer. It's part of the answer, but it's not the whole answer and it really goes against the recovery goals and the mental health principles that I think we're all trying to work towards. Bearing in mind, there are some people that will be on the NDIS that will be better on the NDIS, and we will always support our people to get that if that's what they want.

MS ABRAMSON: What about – and it's a really good point that you've made. The Commonwealth had a number of program cuts in recovery, (indistinct) and de-funded, but then they had to – they realised what the problem was. So would your view be that we need to keep that – those funding streams?

MS GAWEN: Absolutely, and I think you'll see in my report – I could whoosh through all my papers or you could just look at the report. So the money that the PHNs have now got for that is population-based and it's ridiculous. I think we said it would cover eight people in the remote areas of the NT, and that's not – you know, what was the promise for the NDIS? No one would be worse off? They're clearly going to be worse off with that sort of money. So I just – I'm not sure what happened there as to why that was deemed as an acceptable level. But certainly, the need for the Commonwealth government to fund mental health services is really clear and not just, you know, this site's the NDIS, that's the NDIS.

MS ABRAMSON: Thinking about – like, it's not really your space, but we've had a view about governance which is that we put up a model which – we called them regional commissioning authorities, and in our model we presumed what we wanted, that those organisations be able to commission the type of services that you offer. So that was kind of the model that we thought of. So in the current environment, do you get commissioned by the PHNs to provide the psychosocial – I think there's only one PHN in this area?

PROF KING: Yes, one for the area. Yes.

MS GAWEN: Yes, there's one. Look, if I just answer your question generally, the national models just – I don't think would work up here. There's just the one – I understand and we've always heard about the one-stop shop. Are they actually effective? I'm not so sure and I think – like, one of the really interesting things I found when I was – I met a – I had a meeting with some of my Aboriginal colleagues and my mainstream colleagues about the productivity commission report and what we were going to respond, and somebody said, 'well, you know, here's another white middle-class report out of Sydney', and I go, 'is it? What do you mean?' That was – and I'd been here a month, and now I see what they meant. It's – you know we were at those meetings last week and they were talking about, you know, workers – the HESTA lady was talking about workers and their superannuation and, you know, the significant need for workers with a low superannuation, and I understand that that's a significant need. There are homeless, and I just think – and then I look at what happens here and I go, 'gee, you know, we're just really different', and

yes. The messages I got from the board is that that's not a great message, and I go, 'I'm going to keep saying it because I really think it is'. It's – we're really different and, like, can your national model actually take in all of the different variances, particularly in things like the NT. I don't think so.

You know, from my – I've worked in the NDIS a reasonable amount. That's about scale. You know, it sets minimum staffing levels based on the ability to get scale. You can't do that here. So you look at – you know, there are parts of the market in the NT that are flooded and they're flooded because they're the services that make money in the NDIS and there's others that just have no gap – just have, you know, no services because you simply can't make it efficient. So, you know, I've been talking to Miwatj – not the CEO, who was away, but someone else – about coming out – TeamHEALTH needs to come out to Nhulunbuy and set up some NDIS services because no one else is, and we want to work with you around doing that. So you know, we're also looking at that. But making that work with the current model of the NDIS, we're just like, 'gee, you know'.

PROF KING: The process doesn't (indistinct).

MS GAWEN: The process just won't work, and then how do we know that the market is there? There's not enough stats to show us and that's what – also what I'm finding up here. I'm not getting the stats to show – everyone's saying 'there's a need, there's a need'. I'm like, 'where's the need?' But it's just really - - -

MS ABRAMSON: Well, we're actually thinking about that in another context. We've got an inquiry which our Aboriginal commissioner, Wal Mokop, is chairing which is about evaluations and – evaluation in that space. So it's kind of a broader issue than just the programs that we're looking at.

MS GAWEN: So I guess for me, the key issues – or for TeamHEALTH, the key issues are, you know, the NT is different. Like, I think we said in our report, you know, we have five different quite extensive accreditation processes we have to go through that I've never experienced in other organisations. You know, the general 'I've just finished my MBA' and, you know, the big hoo-hah is you just get your niche and you go for it. Well, we wouldn't be sustainable if we did that here. We have to look at different markets and different opportunities. Like, we always make sure we do them well, but it means we just need – you know, when I started I said, 'our admin's too high', and now I understand why. It's because we have, you know, these five accreditation, quality-assurance things that we need to do, it's our diversity of staff, it's upskilling our staff. You know, before they start, we need, sort of, four or five lots of training that they need to do and then they might move in three months because their partner's moved for – in the RAAF and they've gone, you know. So just little things like that that really do impact us as an organisation and our strength as an organisation.

PROF KING: So just one thing, on – because you mentioned Nhulunbuy, I'm not sure if you've been here long enough to answer my question, but I was wondering – because East Arnhem has been a, you know – I don't want to say an experiment, but it's been a change

in the way service is deployed over there, and I was wondering how that's worked from TeamHEALTH's perspective. Has it been good? Has it been bad? (Indistinct).

MS GAWEN: Look, I really couldn't comment. We have no services in East Arnhem Land.

PROF KING: None, okay.

MS GAWEN: No, no services. I was actually born over there, but that doesn't help you at all, and so we're actually just looking at the market now at the very early stages. So yes, I really couldn't comment. But we are really - - -

PROF KING: Okay. No, I didn't realise there were none.

MS GAWEN: No, no services. But we are certainly - we're committed to working with Miwatj to look at, you know, opportunities there.

MS ABRAMSON: I just had one final question. I'm very grateful for that, that you've come along at the end of the day when you have a serious day job, as do other people. Workforce: we've heard a lot about that, particularly the (indistinct) workforce, the (indistinct) workforce. What type of views do you have on that and what makes a difference?

MS GAWEN: I think there's some real positives about the NT workforce, but I think there's also some real difficulties in it. So the NDIS with the set market rates, that makes it exceptionally hard because there are some services you simply – we have to subsidise to offer them as an organisation or we couldn't, based on their unit costings, and it is exceptionally difficult here. Like, we are seen as a really good employer and I think our retention rate is two and a half years, you know. Something like that.

PROF KING: That's a pretty big turnover.

MS GAWEN: Pretty big turnover, you know.

PROF KING: That's about 40 per cent per year, wow.

MS GAWEN: Yes. So it's big, and we, honestly – coming up here, one of the things that I was told was 'gee, how are you going to fit into the Northern Territory? You like processes and structures and you like things – you like frameworks'. It's wonderful. You know, we were a lovely organisation that is really structured and focused and has lovely – you know, our focus has been on supporting our staff so that we can be seen as a good employer, which we are seen – but you know, two and a half years? Like, wow. So we're really struggling with that and it means the CEO is really struggling with that, and we also – you'll see our senior leaders are fantastic. We're trying to get diversity because a lot of them are, you know, middle-aged women who are pregnant and having their second and third babies. So I've put a ban on all babies now. Clearly I haven't. Just - - -

PROF KING: No, I know that that was a joke.

MS GAWEN: So those challenges are difficult for us. The Aboriginal workforce is something we really need to strengthen as an organisation and I'm really keen to talk to some of our partners around how we do that. But it's tricky, you know. So our rule is you need Ochre cards to work with us and you need a current licence. So you have - - -

MS ABRAMSON: Sorry, what was the first thing you said?

MS GAWEN: You need an Ochre card, which is an NT-specific card.

MS ABRAMSON: Yes.

MS GAWEN: And many of our – we have some wonderful Aboriginal people that we could employ but they don't have that. We don't have Aboriginal people in senior management roles. We would love to have some Aboriginal advisory staff. It's difficult to have that. You have to get to a scale to be able to afford those sorts of initiatives, and that's what we're looking at. That's how we're trying to strengthen that. We – I think you'll see in our report, the amount of money we spend on training is significant. You know, we pay above award in many of our instances. I mean, all the NT services that I'm familiar with have extra holidays. So it just costs us more up here and we need to do that to attract the staff that we get. So yes, it's really difficult, and how you actually acknowledge that in the big service system model, I'm not sure. But certainly having minimum – having models set up on an hourly rate is not the way, because that just really impacts us.

MS ABRAMSON: Thank you.

PROF KING: Thank you.

MS ABRAMSON: Thank you very much.

MS GAWEN: Okay, thank you. So would you like - - -

MS ABRAMSON: It's been really interesting, thank you.

MS GAWEN: Yes, I'm sorry that you've probably had a very long day.

MS ABRAMSON: No, but the personal – the stories of what you're actually doing are really helpful and, you know, they're great models. So what we have to think about is what you said about the Territory being different and how scalable things are. That's what we're thinking about.

PROF KING: It's also – yes. It's also important, because you've had experience outside the Territory and come back - - -

MS ABRAMSON: That's right.

MS GAWEN: Came back in, yes. Look, and I can't highlight enough the psychosocial supports. You know, I think we've always gone to the 'we'll just get you more clinicians and we'll just put more hospital beds'.

MS ABRAMSON: No, we're - - -

MS GAWEN: And we're clear that's not the way.

MS ABRAMSON: Yes. It's like I said the other day, and - our report came out with a - it looked like we hadn't really thought about that, that we were clinically focused. But that's not what we intended, so we will think about that for the final report.

MS GAWEN: Great. So I have - I've just got a little bit more information, so the position statement from TeamHEALTH, and just - I thought you might be interested in the Katherine gap analysis.

MS ABRAMSON: Yes, absolutely.

PROF KING: Yes, we'll have a look.

MS GAWEN: Okay, will I give it to you?

PROF KING: Thanks for that.

MS GAWEN: Thank you.

PROF KING: All right, so I do have a statement to make at the end of the day. This is the last hearing, isn't it?

MS ABRAMSON: It is.

PROF KING: So in that case, seeing as there's no one else here that I can invite to give a presentation if they wished to, I will formally close the hearings of the mental health inquiries. Thank you very much.

MS ABRAMSON: And can we thank the staff for their hard work in organising all of this.

PROF KING: Thank you, staff.

MS ABRAMSON: Thank you.

ADJOURNED INDEFINITELY

[4.13pm]