



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

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**PRODUCTIVITY COMMISSION**

**PUBLIC HEARING INTO MENTAL HEALTH**

**PROF STEPHEN KING, COMMISSIONER**  
**MS JULIE ABRAMSON, COMMISSIONER**

**TRANSCRIPT OF PROCEEDINGS**

**AT THE PLAYFORD ADELAIDE HOTEL, 120 NORTH TERRACE, ADELAIDE**  
**ON WEDNESDAY 5 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 the presiding commissioner on this inquiry. My fellow commissioner here with me today is Julie Abramson. Before we begin today, I would like to acknowledge the traditional custodians of the land on which we meet, the Ghana people, and pay respect to elders past, present and emerging, and I extend this respect to all Aboriginal and Torres Strait Islander peoples in attendance today.

The purpose of this round of hearings is to facilitate public scrutiny of the Commission's work and to receive comments and feedback on the draft report. This hearing in Adelaide is one of many that we're having around Australia in all states and territories in both capital cities and regional areas. We will then be working towards submitting our 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 report's release by government, which may be up to 25 Parliamentary sitting days after completion.

We like to conduct the hearings in a fairly informal manner. I'd like to remind participants, however, that the legislation does dictate how these hearings can be conducted. For that reason, a full transcript is taken of the hearing, and so comments cannot be made from the floor. They simply don't get on the transcript. The transcript taken today will be made available to participants and will be available from the Commission's website following the hearings. Now, the microphones that you have here are purely for the purpose of the transcript, so if I could ask people who are providing evidence before the hearing today - if they're able to speak up, that would be fantastic. Otherwise the people down the back have got a ways to move forward. Also, just a reminder, make sure your mobile phones are on silent.

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

**MS ABRAMSON:** Lisa and Katie.

**PROF KING:** Lisa and Katie. In the unlikely event of an emergency requiring evacuation of this building - Lawson to advise on the day.

**LAWSON:** Downstairs and evacuate through the revolving door.

**PROF KING:** Fantastic.

**MS ABRAMSON:** He's much better at that than we are, Stephen. We never get the evacuation right.

**PROF KING:** I think evacuating through the revolving door in the lobby is a really bad idea.

**MS ABRAMSON:** We can comfort the participants. We've never had to do this.

**PROF KING:** Our first participant today is Philip Armstrong. So Philip, welcome. If you're able to state for the transcript your name and the organisation you represent and any opening remarks that you'd like to make.

**DR ARMSTRONG:** Thank you. Thank you very much for inviting me to speak at the Commission. My name is Philip Armstrong. I am the CEO of the Australian Counselling Association. ACA is the peak body for counsellors in Australia, with close to 6,000 registered counsellors and members. ACA does work closely with other organisations within the counselling industry. We work very closely with another organisation called Psychotherapy and Counselling Federation of Australia whom we are a partner organisation of for the Australian Register of Counselling and Psychotherapists, so ARCAP. If you hear me use the word ARCAP, that's what I'm talking about.

So ACA welcomes the Productivity Commission's draft report into mental health and we applaud its focus on system reform, early intervention and prevention, the cross-episode coordination and supports of mental illness and its attention to creating reforms centred around the needs of customers or consumers, sorry, and their carers. To ease my presentation and save confusion, when I refer to the term "counsellor", this term also incorporates the term "psychotherapist". ACA has a longstanding protocol of accepting that they are both one and the same. There is – the most significant difference between the two is the obvious: it's the spelling. So ACA members may refer to themselves as psychotherapists or counsellors. However, neither title esteems to reflect any superiority in training or abilities to work with mental health clients. So just to clarify that when I say "counsellor", I'm not neglecting psychotherapists. I just want to keep this as concise as possible. Also, when I refer to the term counsellor outside of any research or quotes I may make, what I am referring to is an ACA registered counsellor, which is very important, okay. So we're defining who the counsellors are.

Okay. So ACA contributed to the ARCAP's submission, which - I would hope that has been read. So I'll attempt not to double up on any information that you would already be aware of from that submission. Since the release of the draft report, many counsellors have had the opportunity to provide evidence at the Commission as part of the hearings. I'm pretty sure I'm not the first one that you guys would have heard.

**MS ABRAMSON:** No, we've had a number of your colleagues.

**DR ARMSTRONG:** That's great. So these opportunities have provided invaluable feedback to me and helped inform my address today. What I've done is I've attempted to

read as many transcripts as I possibly can that have included counsellors - also by some psychiatrists and psychologists – to help me to try to – hopefully give me some new information, as opposed to going over old information. But again, from the questions I've read I also ran into some confusion. So hopefully I can clarify any of that confusion while we're here as well. So the draft – while the draft report recognises counsellors and psychotherapists as a self-regulated allied health profession, it does not adequately acknowledge the qualifications and skills of counsellors or their potential to positively contribute to the mental health outcomes of Australians through providing and performing services within and outside the health sector, and I'll be a little bit more specific on that issue later.

First of all, what I want to do is let's just have a look at who are registered counsellors? Who are we? Okay, so everybody understands who registered counsellors are. So the profile of an average ACA registered counsellor is someone between the ages of 40 and 60 who is usually on a second or third career change. 75 per cent of our members are female. A large proportion of our members have grown families or teenaged children. The average member will be someone who most likely already holds a formal qualification from a past career, and we had - a significant amount of our members are past teachers, social workers, medical doctors and nurses. Other members come from professions such as the police service, military, ministries, belief systems and stay-at-home mums whose children have left the nest and they've chosen to come into the workforce. There is a great percentage of refugees and immigrants also coming into the profession. There are a significant amount of multilingual members, particularly from Asia, South America and Africa, which again reflects the amount of immigrants and refugees that are now coming into the industry, and a lot of them are coming in with overseas qualifications and we do find a lot of them to be very good. In comparison with Australian qualifications, a lot of them are on par, which we do find interesting. So a proportion of our members also have lived experience of mental illness.

So many people ask, what is the difference between a counsellor, psychologist, psychiatrist and social worker? Most people will answer with an answer that is based on qualifications and a registration process, as no doubt you have heard. But I think people actually miss a more important difference. What are – the significant difference is the qualities that counsellors bring to mental health that others do not. Age is one. The average counsellor, when they graduate, is 40 to 45 years old, in comparison to the average psychologist and social worker, who is approximately 26, and psychiatrists, who are around about 28, give or take a year. Another significant difference is, all the disciplines – out of all the disciplines, counselling is the only one where the average new graduate already has significant work and life experience prior to graduation. They can speak from a perspective that most new graduates in any other profession cannot. They are able to get this from the get-go. They legitimately understand life's challenges beyond being a youth and studying. They can draw on real-life experiences, not just theory.

Having 20 or more years of life experience before coming into the profession also ensures counsellors are resilient. Due to their life experience, counsellors are reticent about

making a diagnosis and prefer to simply work with the human being in front of them, listening to their story, which in many cases is complex with many layers, before determining if a diagnosis is necessary or, in fact, in the client's interest. This should not be misinterpreted to mean that counsellors are not qualified or trained to make a diagnosis. A common myth held within mental health, that counsellors are not qualified to do that. Many are.

What does "registered" mean? So we'll just clarify what does "registered" mean when I say "ACA registered counsellors". So each member of ACA – and this goes for ARCAP in general. So each member of ACA has been able to verify through formal documentation that they meet ACA training standards. They undertake regular clinical supervision, undertake regular professional development, and adhere to a stringent code of practice which incorporates our complaints mechanisms. Our members also have to adhere to legislative requirements depending on the nature of their position. ACA requirements are rigorous. All documents must be verified by a JP against their originals. ACA membership documents are audited by an external auditor independent of ACA each year to meet legislative requirements in regards to private health funds and the legislation that comes through the private health funds. Once a member meets all requirements, they are placed on the ARCAP register. We – to give you some perspective, we probably knock back, on a weekly basis – we – right now, we're averaging around about 100 new members a month. We average around about five or six applications a week from psychologists and social workers who do not meet our standards and therefore we refuse them membership. So I think that's an important thing to remember, too - that simply being a psychologist or social worker does not meet ACA membership requirements.

So one of the questions I did notice was when you talk about research - there's been a lot of statements made around research. I'll clarify that for you. So over the last 30 years, hundreds of mental analyses have been conducted on the efficacy of psychotherapy and counselling, and what the summaries of these meta-analyses suggest is average effect size for counselling compared with no treatment control is somewhere around .75 to .85 of a Cohen's d scale. For those not familiar with the research, the Cohen's d scale is used a lot within mental health to measure outcomes. To give you a perspective - so we're saying that the outcomes are .75 to .85 - .2 on the Cohen's scale is small, .5 is medium, .8 is large. So in other words, counselling has a large effect – substantially larger than many medical or surgical procedures, which have an overall effect size of .5. I have all the references for these statements, should you require them. Be a bit silly to make them without the references, wouldn't it?

So summarising 28 clinical trials, Hansom found that around 60 per cent of clients in psychotherapy improved to an extent that was clinically significant. Studies of therapy in clinically representative real world – when we talk about being clinically representative, that's just a term used in mental health for "real world". So studies of therapy in real world conditions generally indicate that it's highly effective. For instance, within a U.K. primary care setting, Styles and colleagues in 2008 found that around 58 per cent of counselling and psychotherapy clients achieved reliable and clinical improvements. So

what about measuring? Okay. Studies using routine outcome measures, such as the clinical outcomes for routine evaluation, as we call CORE, which is used primarily – it's very heavily used in Europe, particularly in the U.K. We - as a counselling association, we're trying to get it introduced into Australia, while we are aware that there are some NGOs in Australia who are using CORE. So CORE have reported reliable post-intervention improvements for counselling in three quarters of clients and demonstrated persons stated counselling to be an effective intervention for clients with common medical health problems.

Another interesting point to note in the research findings is that they reflect that counsellors are more highly accepted by clients than either psychologists or psychiatrists, and that was an Australian study done on the Gold Coast by Sharp, (indistinct), and they are also seen to be more approachable and empathetic, said the study by Sharp. There is a strong evidence base that providing services according to client preference improves therapy outcomes, and I think your report actually clearly does indicate that. So I'm just repeating what we do know there, and the reason why I put that in there is I think that it's very important to put that in context with the research that I'm talking about, that counsellors are not only effective but a part of the system, and from the research - although it's not large, like most mental health research – there is an indication that in the real world, the consumer is – much prefers to see a counsellor than anyone else as a first option, and yet that is not the opportunity that they're given through the MBS in Australia. We're not even an option, even though we are considered to be a first choice. So access is significant.

So what I'm going to do for now, I just want to quickly go over courses. So what qualifies a counsellor to be a counsellor from the accreditation process?

**PROF KING:** I'm just wary of the time, because we would like to ask you some questions as well.

**DR ARMSTRONG:** Absolutely.

**PROF KING:** So – I mean in the sense, courses and so on, we are able to look up ourselves through university and college websites.

**DR ARMSTRONG:** I think – well, the reason why I brought that up is there is a difference. ACA has its own accreditation systems, so just because a course is out there – I remember one of the comments that was made by – I think it was a psychiatrist in Melbourne, “Anyone can train to be a counsellor because they can do an online course”. Well, that's not correct if you want to be a registered counsellor. That's why I'm just following that up.

**PROF KING:** I understand.

**DR ARMSTRONG:** Thank you. You saved me a bit of work there. Okay, and to – just to help you understand, ACA has a level system for membership. So we have level 1, 2,



3 and 4 for practicing counsellors. So I'll just quickly explain that. So level 1 are diploma graduates, and that was why, actually, the thing about the accreditation is there are only four diplomas on the training pages that ACA accredits. So you can't just do a diploma, either, and that's because of the – mainly it's because we don't just accept online training. We have specific training standards. So there are only three diplomas we actually accredit through the Association. So our level 2 members are either Bachelor degree graduates, so new graduates, or diploma graduates with more than two years' supervised practice. Level 3 are members with either a Bachelor's degree or a Master's degree who have a minimum three years' post-qualification with a minimum of 75 hours' supervised practice and 750 hours' required contact time. Level 4 requires six years' post-qualification with a minimum of 100 hours of supervised practice and a minimum 1,000 client contact hours.

If you actually want to do a mapping exercise, our level 3 and 4 requirements are higher than that which current social workers and mental health nurses require to register for Medicare provider numbers. I think that's an important thing to remember. I don't think we need to prove that we are equivalent to current providers. It's already there. Level 4 is higher than the requirements for a general psychologist, with level 3 being equivalent or higher depending on the psychologist's pathway, which you would be aware there is – I can't talk for psychologists. There are several pathways. My wife's a psychologist, so I have a working knowledge, but I'm not here to talk about psychologists, and none of this is meant to be a criticism of any other discipline. I'm simply pointing out the differences.

**PROF KING:** I understand.

**DR ARMSTRONG:** The stepped care model – and what I've brought for you, just to help you with this – there's a little bit of a map there, because I did notice one of the questions - - -

**PROF KING:** Thank you, sorry – just for the transcript, we've been handed just a one-page document.

**DR ARMSTRONG:** So I noticed on one of the questions the Commission did ask was how does – how do we see counselling fitting into the stepped care model, which is a very important question. So how do we see it fitting in? Looking at the diagram I've given you, the way we see it is that counsellors absolutely fit in and I think what hasn't been made clear to the Commission is that we fit in all places of stepped care. Unfortunately, some people have just spoken about counsellors coming into early intervention or primary care. That doesn't do counsellors' qualifications and the use of the training they've done justice. What we see is that within stepped care, primary care service would be level 1, 2 and 3 members; step 2, which is low-intensity service, level 2, 3 and 4; and step 3, high-intensity service, we see level 3 and 4; and complex treatment service, we see 3 and 4. Just to clarify for the Commission, when we talk about levels 3 and 4, we're not talking about individual counsellors practicing at those levels independently. We're talking about counsellors being part of multidisciplinary teams, so working with psychiatrists, clinical psychologists and such. Certainly, we wouldn't be suggesting levels 3 and 4 as

independent practice, and I think most people who work within the high-intensity and complex do work within interdisciplinary teams in any case.

What I'd like to do, though, is - just to demonstrate what I'm saying, is read a letter that we have here. Now, obviously I can't identify this person. But this is from the North Melbourne – North Western Melbourne Primary Health Network. Now, I don't know if the Commission understands the PHNs, but they're a - what we call lead - - -

**MS ABRAMSON:** Yes, you can take it that we do.

**DR ARMSTRONG:** Absolutely great. So you'll be aware, then, that North Western Melbourne is a lead PHN. So people are taking what they do as being – works. Okay, so let me just read this.

*I wish to advise –*

and I can't mention his name -

*– has been contracted by the North Western Melbourne Primary Health Network since 2016 to deliver a range of mental health services including targeted psychological support services, focused psychological strategies, suicide prevention services, counselling, intensive support services, and coordinate care for people for people with severe and complex mental health needs. (This person) holds an independent contract with the PHN and is subcontracted by psychiatrists in the delivery of intensive support services. During 2018/19, (the gentleman) delivered almost 500 hours of service interventions, including approximately 100 hours of direct counselling through (the organisation). He regularly attends mental health provider forums and has satisfactorily met our clinical governance requirements refine reviews, which are conducted annually. We have not identified any issues warranting concern either from client feedback or operational.*

That is a letter from a level 3 member of ACA, and the reason I think it's important that this letter be read out to mention is to reflect that we are already doing the work. We are already employed within PHNs and contractors and tenders to be working at the high-intensity and complex treatment service level, but also within, obviously, step 1 and step 2. But we are already doing it. It's an irony that we have to sit here – and certainly this is no criticism of the Commission, but it's an irony we have to sit here and try to justify to the world why we should be allowed into things such as the MBS when we are doing work that is above people that are already registered and given access to broader numbers. We shouldn't have to be continually proving who we are, what we are and how we work when the industry itself already recognises it. As I said, that's a level 3 member of ACA who is working within – actually doing the work that we're now asking everybody to recognise that we're capable of doing. We're already doing it. That is one of many, many of our members who are working within the system at these levels.

So this brings me to my next point: outcomes. So registered counsellors have equivalent competency skills and experience in delivering evidence-based psychological strategies to other allied health professionals and are already eligible to provide MBS-funded services, and I've just given you an example. This gentleman would – if he was a psychologist would be standing on his head getting into – an MBS provider number. It would be a matter – just an administration point. So there's no research that reflects any one type of therapist, being a psychiatrist, psychologist, social worker or counsellor, who gets purer results or greater efficacy than the others. It would be a fallacy, or a myth, for any of us – including counsellors – to suggest that we get better outcomes. The research just simply does not support that intention. But the research is very strong that actually, we get equivalent outcomes. So we do get outcomes, but they're generally equivalent to each other.

A study by King and colleagues in which non-directive counselling as practiced by bona fide accredited counsellors – these were in England – was compared with CBT as delivered by qualified psychologists showed an almost identical reduction in levels of depression across two therapies. This study reflected the same outcomes from another study in the late '80s by the U.S. National Institute of Mental Health Treatment of Depression Collaborative Research Program, which is considered even now to be the most methodically sophisticated study ever done. The large majority of research not only reflects that not one discipline is superior in getting positive outcomes, the process of reaching this conclusion has also shown that longer periods of formal training, such as mandated additional graduate qualifications, also have no impact on outcomes, which is something else that tends to be overlooked when you hear some people who go on and on and on about the more qualifications you have, the better practitioner you are. The research just doesn't support it. Obviously, the research does support that you need qualifications and training, but there is a limit.

So what works in therapy? So research from (indistinct) consistently demonstrates outcomes of therapy primarily relies on – and this is why my previous statement is so important, because what research has found is that the – a lot of outcomes are more dependent on the quality of the therapeutical relationship, the strengths of the therapeutical alliance, and the therapist's level of empathy, which is something that is taught to all psychologists, psychiatrists, counsellors and social workers. It is not taught independently to simply one discipline, which is why, probably, we all get equivalent outcomes.

One area that we do find – and again, identified by the Commission – where there are significant issues and we know counsellors could absolutely have a significant positive impact is in rural and regional areas. There are significant chokepoints all around Australia where patients requiring mental health services under the MBS are placed on long waiting lists. For example, patient waiting times in days to commence treatment under Better Access initiative in the Hunter Region can be up to 25 days. There's currently over 200 registered counsellors in the Hunter Region who are available but can't be used. That would make a significant difference to those waiting lists if those counsellors were able to support those clients. There's – okay, covered that. There's also – I mean, there's Armadale – we've got a whole raft of regional - and you'll be aware - of regional areas and rural areas where there are significant waiting lists. In just about all of them, there are

counsellors who would be eligible for MBS rebates should it be – happen under the models that we talk about who would be able to support those patients.

So young people in rural areas experience differential access to Medicare-funded services such as psychological treatment. They experience significant wait times to access psychological counselling, averaging six days to be assessed with a maximum daily wait time of 23 days and a commence-treatment time averaging 15 days with a maximum daily wait of 41 days. Now, that's from the HNECC data. These are just three examples of hundreds where counsellors are being underutilised at the unnecessary expense of mental health consumers. There's a lot of – and also anecdotal evidence that we're aware of, and there's one I remember going back two years in the Hunter Valley where – as I said, this is anecdotal – where people have actually suicided on waiting lists because they've been waiting for services, and to think that there's over 200 counsellors qualified to have helped those people – that's just a tragedy. It should never have happened. So it's a fault within the system.

**PROF KING:** Very keen to follow up with some questions on that, by the way, so – but I'm very wary of the time.

**DR ARMSTRONG:** Okay, I'll cut this down for you. So what I've also noticed that you asked for, obviously – I won't go too much on MBS. One thing I'll state is ACA and ARCAP, we are very aware a) that the MBS rebate is not a panacea for counsellors. I know there were a lot of very frustrated and desperate counsellors who made submissions and who you heard speak and a lot of them did talk about the financial issues. But that's simply because of the frustration where - when you're receiving phone calls every day – not just once or twice but every day – from people that are desperate to receive counselling because they're on waiting lists and you have to tell them you can't help them or you have to offer, you know, pro bono services, which is not – you know, the Australian psyche is very much “fair day's pay for a fair day's work”. So, like, counsellors, out of all mental health professionals, should be expected to work for nothing like that? No, particularly after spending a significant amount of time getting qualifications and the registration process. So a lot of that comes from that. So I won't go too much into MBS. You would have heard all about the MBS. Let's have a look outside of MBS.

One of the things that we have thought about is that maybe it would be an idea if the government was to develop a funding stream to have counsellors embedded within GP practices to work with subacute patients. That would be an area where we could certainly – particularly those even with acute services, complex services, we can manage them whilst their waiting for – to go to acute services. We know there's a shortage for psychiatrists in Australia and certainly - counsellors working within a GP system can certainly manage them to ensure they don't suicide, help them with whatever medication they're on, and to be able to manage them until they can see the psychiatrist.

**MS ABRAMSON:** Sorry, I just wanted to ask a question. With that model that you just proposed, what prevents it happening at the moment? Because you spoke about the North

Western PHN in Melbourne and they're already doing that. So if it's not an argument about MBS, which – we understand that argument, why wouldn't that happen in any event?

**PROF KING:** The PHNs have got the – what was the mental health nurse in GP clinics - -

**MS ABRAMSON:** That's right, the funding. Yes.

**PROF KING:** - - - and they could use that for counsellors.

**DR ARMSTRONG:** Because there is a resistance within - certain PHNs tend to be run – how do I be politically correct on this one? They tend to be monopolised by certain - - -

**MS ABRAMSON:** You just think there's a cultural – what you're saying is there's a cultural issue?

**PROF KING:** It's an issue for PHNs.

**DR ARMSTRONG:** In some PHNs, yes. Absolutely. We have rung up and contacted every PHN. Some won't speak to us, some are very opening and they – like the North Western Melbourne, and some are just ambivalent, and again, a lot of that's to do with culture within those PHNs. Certainly the research doesn't seem to matter, particularly the tendering services. A lot of the tenders that go out are written in such a way as they claim to be balanced and open, but if you actually read the writing, they then talk about “one must be registered with a certain college”, which then just cuts out 95 per cent of applicants. So you know, look, you're not even given a chance to apply or be assessed on your abilities, let alone anything else, simply because you're not a member of a certain college, which is just ridiculous. It's biased. So that's what does – so a recommendation from the Commission would go a long way into helping support us to get that model off the ground.

**MS ABRAMSON:** See, I would say to you that in our model, we've proposed two types of - the rebuild and the renovate model. But in our regional commissioning authorities, it would be our expectation that they could commission the sort of services that you're talking about, just like the PHN. But what you're saying to us is that there is actually a cultural issue as well. So even though they can do it – leave aside – MBS to one side. Even though they can do it, they're not doing it, and the reasons that you suspect for that is, like, a culture around who can help whom at what time.

**DR ARMSTRONG:** Absolutely. That is – there's also a (indistinct) issue that comes into it. A lot of these services – and one I was going to talk about is even when we look at employee assistance programs, and a lot of contractors – what they do is they'll put out a contract for a mental health professional to deliver a service on the basis that that provider has an MBS provider number, and what they'll do is limit the funding to maybe three sessions and then what they'll say is, well, after those three sessions, to ensure there's continuity within the counselling process – because we know the majority of people need far more than three sessions to get any sort of positive outcome – we'll then go on to MBS

Better Access to keep the cost down for the clients. Well, the fact is, we don't have access to Better Access. So as soon as they put that in the contract, counsellors are out and so are a lot of other mental health workers, on top of the fact that they then put "got to be a member of a certain college". So it's cultural, but it's then the – what is also added to the obstacles that are put in our way is they then say you must have an MBS provider number so you can continue to deliver your service through. So it's not double-dipping, because that's illegal, but it's a pretty - - -

**MS ABRAMSON:** No, no. It's a business model. I understand.

**DR ARMSTRONG:** Yes. It's legal and it makes sense. But what it does is it prevents the counsellors from coming into the system. So that's the other obstacle that comes in with – there. So unfortunately, MBS does have peripheral impacts on us because that's how a lot of organisations work. Even a lot of NGOs will subcontract mental health workers on the basis they have provider numbers, and if you go through the employment ads, you'll see it's quite clear in a lot of them. So again, counsellors are out of the picture.

**MS ABRAMSON:** Dr Armstrong, you mentioned the Hunter Region and you said that counsellors can't be used, and yet – you mentioned a quite tragic circumstance there. Is that because of the arrangements of that local PHN?

**DR ARMSTRONG:** Yes. Also the fact that we can't – because what a lot of - obviously, a lot of people – the Hunter Valley people, in those days, just didn't want to hear it. A lot of people there relied on the Better Access system to get entry to mental health services because those counsellors don't have access to it and they can't offer their services.

**PROF KING:** Just – so culture and, as you said, the issue of Medicare provider numbers allow you access to a certain pool of funds and allows a PHN or another commissioning agency to (indistinct), if I can put it that way. Our models that we recommend explicitly avoid that problem, particularly the rebuild one, by saying, well, if a – you know, nominally, any access to Medicare funds is a budget item for the commissioning authority. So if we remove the dollar issue – so if our recommendation is accepted there, what can you do about – what should we be recommending to do about culture? Because we've said we fixed one of the problems – you can see our recommendation does, but that still leads to culture - - -

**DR ARMSTRONG:** But – it's an interesting issue. I've been in the industry for over two decades, so I was in the industry before MBS. So in 2006 when the Liberal government introduced it - and pretty much it was introduced as a last-minute way of getting votes, let's be honest. It was – obviously there were good intentions behind it, but it was a last-minute idea and we weren't consulted during that process. So counsellors were left off, but prior to that, I had a private practice and we would be – my private practice and most counselling - prior to 2006, GPs would refer to us before psychologists. A lot of that was a cost issue – counsellors were cheaper – but before that, there was not an issue – before that, we had – we worked in ATAPS, which we've now been taken out of although we worked in it for over 10 years. So there's no – and there was no reason we were taken out of it. As in, lack

of effect or anything else. So prior to 2006, the medical system had no issues with using counsellors. We've spoken to – we had a meeting with the rural – the office of the rural GPs in Brisbane a couple of weeks ago and they said they would love counsellors to come back into the system, and so would the GPs because it gives them better options and greater choice when doing their referrals. So I don't think they would – if counsellors came back into the system, there are a lot of people within the system – and I've read some of the transcripts where you've had psychiatrists, psychologists and social workers who've all said they can't understand why we're not in the system. So there is also a – still a strong positive attitude towards counselling within the system and I think that would certainly go a long way to doing it, would be the positivity that comes back into access and choice. But also - I think it would be up to organisations like the Australian Counselling Association to develop public education programs, but also we would have to look at the PHNs and do professional development workshops for GPs and for mental health providers in all government organisations. That would be, certainly, a job that ACA would have to take on as a peak body. That's our responsibility. So I think that could quite easily be done over a period of, you know, 12 to 24 months, just educating. But also – we'd also be then hitting up the government for funding to do television advertising, whatever.

**PROF KING:** But it sounds like if we're able to fix up the dollar incentives, that would go a long way.

**DR ARMSTRONG:** Absolutely. I mean, we used to work with divisions of GPs before it became the PHNs.

**PROF KING:** I'm really conscious of the time, so any final comments that you want to make, and then I'll just check if we've got any more issues that we want to - - -

**DR ARMSTRONG:** Two final comments. One is the GST issue. A recommendation to have counsellors be made exempt from GST, that's simply a point of legislation and it's a ridiculous legislation in the sense that, you know, counsellors have to charge GST where psychologists, social workers and the rest - who are providing counselling services, mind you – don't have to pay GST. The issue – or the reason why a counsellor has to pay GST is because GST is not payable on a GP-referred program. So a GP can't do up a healthcare plan for a counsellor.

**MS ABRAMSON:** Can I just say, Dr Armstrong, it may be even more difficult to change the GST system than the MBS system. I speak with experience here.

**DR ARMSTRONG:** We've had three goes at it. I believe there's only one that's ever been successful and that was women's healthcare products. It's been the only one that's been successful and I understand that, and that's not an important one. But I just wanted to reflect to the Commission that we're looking outside the MBS box. There are other things that need to be done. The – one thing is, I mean, we have – I've also, maybe, picked up, correctly or incorrectly - there seems to be a concern that - if the Commission was to make recommendations that they probably wouldn't be taken seriously because of the financial issues, I think.

We have an economic argument which we've made on several occasions. I won't go through it today. But I did want to just make it known that I've had significant meetings with the minister's office and minister's advisors and they have been very clear that should a recommendation – and they have encouraged us, which is why we've had so many counsellors here, too – we have been encouraged to get recommendation from the Commission that counsellors go into MBS and the Better Access initiative and – plus recommendations that we won't get the money – and the minister's office will absolutely take them seriously.

The Minister is very much in our court in that he would like to see counsellors come into the system, particularly from a departmental perspective; that there should be more counsellors on round tables and the such, and a lot of the reasons why they're not is because a lot of them require people from the MBS system to be advising. So from the Minister's office, my perspective from what he's told me directly, this is Minister - the Honourable Greg Hunt, he would support a recommendation. Obviously, he can't make them actually happen, but he would certainly be in our court to try to make that happen.

So it is serious, and you know, I think it's important that the Commission realises that it would be taken seriously, and we take it seriously, and so we would strongly - - -

**PROF KING:** I hope all our recommendations are taken seriously, so yes. (Indistinct).

**MS ABRAMSON:** No, no, I asked just as we were going along.

**PROF KING:** I just wanted to get from you - and apologies, because unfortunately with the number of submissions that we do go through, I don't think I've seen the data on the - I don't think I've seen the data on the geographical spread of counsellors. I don't know if you've given that. If you haven't, that would be really useful data to give

**DR ARMSTRONG:** We will, absolutely.

**PROF KING:** Because obviously issues that you mention, with regional and remote. Also understanding some more about, if I can call it - and obviously, you can't answer these now - but measurements of spare capacity of counsellors. And the reason is that when we've had some of our remote hearings and we've talked to some of your members, and they've said, well, you know, it would be great if we're under (indistinct) yes. Great under the MBS. But then when asked, well, but there's a shortage of counselling services here, how much spare capacity? All my books are full.

And obviously that creates an issue if you're saying, well, I'm working to capacity but counsellors moving onto the MBS will increase capacity, and we need to - and please feel free to put in extra submissions.

**DR ARMSTRONG:** The average counsellor wouldn't be at capacity, and over 75, we've already done - over 75 per cent of ACA registered counsellors were outside of major CBDs.



**MS ABRAMSON:** We're really, really interested in this region and rural, and where your counsellors are.

**PROF KING:** And the other one, as you mentioned, CALD communities and multilingual.

**MS ABRAMSON:** Yes.

**PROF KING:** And again, not for now, but if you're able to give us more details on that, that really would be excellent.

**DR ARMSTRONG:** Yes, absolutely, and we have significant Korean, Chinese, and we actually have a Muslim group down in Melbourne. (Indistinct).

**PROF KING:** Again, if you're able to give us - you know, it doesn't have to be a complete - - -

**MS ABRAMSON:** And in the absence of our Assistant Commissioner, we're saying we don't mind late submissions on that.

**DR ARMSTRONG:** Okay. All right then.

**MS ABRAMSON:** No, that would be really helpful.

**PROF KING:** Does that mean we're going to get a text in two minutes - - -

**MS ABRAMSON:** Probably. Probably we will.

**PROF KING:** - - - saying (indistinct).

**MS ABRAMSON:** We will, we will.

**PROF KING:** All right. Thank you.

**MS ABRAMSON:** It would be really - one thing I was just going to ask is, with the CALD communities, it's an issue where we're quite concerned about how we can provide services that are both language and culturally appropriate. So the worked examples of how some of those - the Korean, the Chinese, that would be really helpful. The other issue that would be helpful for us is, there are a whole range of different cultural groups in Australia, so one of our difficulties is, well what - where would you start? What sort of communities? So the work that's already been done would be very interesting to us. Thank you.

**PROF KING:** And getting numbers on the threads.

**MS ABRAMSON:** Yes.

**PROF KING:** Where the services are remote and that sort of thing.

**MS ABRAMSON:** Thank you.

**PROF KING:** Thank you very much, Dr Armstrong.

**MS ABRAMSON:** Thank you. They clap here. They didn't clap in Launceston.

**PROF KING:** They didn't clap in most places.

**MS ABRAMSON:** But they clap when we shut up probably.

**PROF KING:** That's important. Our next presenter is Julianne Martin.

**MS ABRAMSON:** No. Julianne is with the Australian - it's Mr - - -

**PROF KING:** Okay. Bob Riessen. Sorry, okay. So our next presenter is Bob Riessen.

**MS ABRAMSON:** Thank you.

**PROF KING:** And again, just for the transcript, because obviously the transcript can't see papers, we've just been handed a two-page document by Dr Riessen, and if you're just able to state your name, any organisation you're representing, and any comments.

**DR RIESENEN:** Okay. Dr Bob Riessen. I've been a retired GP. I've been advocating in mental health for 45 years, not only in practice, but running meetings for GPs, attending specialist meetings, running a show on the ABC with Peter Goers, and in retirement, still active re advocating for mental health.

**MS ABRAMSON:** So not so much in retirement.

**DR RIESENEN:** Yes, so I've presented - I've written a submission and papers to the Productivity Commission and - but I've summarised them, because I want to tackle it, because I realised in listening to your transcript, in listening to the Mental Health Commission's communications paper to the World Health Organisation, and I know that you must be full bottle on information that's concerning people around mental health in Australia.

And so I'm tackling from - and the idea came from the importance of observation. Max Bazerman in his book, *The Power of Noticing*, said what every good leader have. Described all the facts and figures that were present to them before September 11 and before the world Global Financial Crisis in 2008, and he said, all this we could have acted on, but didn't. So I'm looking back now at the last few decades of mental health in Australia and looking what we could have acted on, and what - you know, just what's gone wrong, perhaps.

So for 45 years, I have observed increasing mental health, mental illness, and decreasing mental wellbeing in the community, and it's just as though we're not meeting the consumers or carers demands, or society demands for equity and human rights. Secondly, if we look at the cause of why we're all here, and why we're discussing mental illness, if it's our genes that are the bullets in our personal guns, as it were, it's lifestyle changes - and that's the paper that I put on your desk - it's lifestyle changes that pull the triggers and cause the damage.

So, I don't think we've done enough to look at these lifestyles factors at the first time of impact, which I think is at conception. There are even studies now done in preconception that look at epigenetics and look at how we can modify genetic behaviour. Society, I think, and these are my observations, has changed at a rate where healthy mental health or wellbeing adaption has failed to keep up. News and information, for instance, bombards our minds at ever increasing in frequency and intrusiveness, and therefore influences our lifestyles in unhealthy ways. Just one quickly, (indistinct).

It influences other things in our cognition, our behaviour, and in our moods. So some of the result of these lifestyle stressors, I think, have shown other unhealthy changes in our society. There seems to be less respect, less individual responsibility, less resilience - that's the ability to pick you up - yourself up from minor setbacks. And, of course, they all have secondary effects on other people. I don't think there is one area in life, from conception on, that good mental wellbeing doesn't have an impact, and I think the costs of people not being at the top of their game extend right over the full period of our lives.

The current medical health system, for my mind, is heavily weighted towards those businesses, research professional entities, that benefits from influencing the system, and I'll talk more about the implications of the previous speaker later. The cost of poor mental wellbeing affects this country enormously, I think, and I - but it's only the tip of the iceberg. Below the surface, we have this swirling ocean of people who are underperforming, who are perhaps to have other symptoms, and I think from an economic point of view, if every - if you could imagine everyone performing at their best, how much better this country would be.

**MS ABRAMSON:** We put some numbers on that. Productivity numbers.

**DR RIESSEN:** Interesting. I could give some examples that would give an indication of just the economic intrusion into individual's lives and (indistinct) to other areas. I don't know how much time we've got. So a lady in her mid-forties attended her local state mental health clinic. She had a blood test. She said, 'I'm down to my last tablet.' And she said, 'Oh, look, there's no doctor here.' 'Well, come back tomorrow.' So she had to come back to that clinic the next day, got the results of the blood tests. 'Oh, now I've run out of tablets. Oh, well, where's the doctor? Oh, there's no doctor.'

Script wasn't ready. 'Oh, look, go to your chemist and we'll fax it through.' She went the chemist, wanted an hour and a half, and still nothing. The chemist said, 'I've got to close,

I've got to close.' Well, he rang the medical clinic; no service. He had the client - this girl had panicked, and she was - received inappropriate medication from her family, and you know, and it aggravated her illness. I mean, there are numerous cases. I could go on and entertain - - -

**PROF KING:** (Indistinct) these scripts will get around that sort of problem, and that legislation's been put through already, I think.

**DR RIESSEN:** Yes, yes.

**PROF KING:** Federal parliament.

**DR RIESSEN:** Yes.

**PROF KING:** So I gather this (indistinct) another hat on - - -

**MS ABRAMSON:** Yes, Stephen's pharmacy inquiry intrudes it.

**DR RIESSEN:** Well, just a quick point pharmacy. Yes, pharmacies are intruding the realm of general practice, as it were, and - but of course, what are pharmacies? They sell. They don't mind how they do it, but they get people in the shop, they get - like bums on seats, they get people in store. They can sell them other things. So I can understand - - -

**PROF KING:** Including homeopathy, which we won't go down that argument.

**DR RIESSEN:** Yes. I can see the - - -

**MS ABRAMSON:** Stephen, we do not want submission from the pharmacists.

**DR RIESSEN:** I can see the energy behind all their - all these things, but, you know, there's a cost to it.

**PROF KING:** Yes.

**DR RIESSEN:** Anyway, I won't go into all the examples that I could have, but they reflect on not only state mental health services, on training of GPs in emergency departments, they look at psychiatrists who are already seeing people, and yet they still suicide. I could go on and on and on. There are anomalies in the system that we, you know, need to address, but that may be not your job from the economic point of view.

But, getting back to the genetics and lifestyle, that paper I gave you by Charles Nemeroff that came out in January from Austin in Texas looks at what are the most significant factors that affect mental health and its evolution, and I'm - and I agree with it. And this what my submissions have been about. It's about seeing if there is some way of optimising the mental wellbeing of every lady from conception right the pregnancy, and then, with her chosen partner, right through the formative years of that child, and then

hopefully supplemented by an educational system that continues to maximise wellbeing through to maturity.

I think so many of the problems, and you can start off with household domestic (indistinct) and you could go right through substance abuse/crime, attitude in workplace, attitude to study. It doesn't matter, there is not one area in life that optimum wellbeing doesn't have an accepted parting. And so, I think the - and the - you would understand the economics of that, because when someone's not functioning at their best, they are more likely to have time off work. They're more likely to be slower to get back to work. When they're working, they're not as innovative, not communicating as well. I think if you look at the economics of all that.

I mean, we could select just one of those things I alluded to, and that is just substance abuse. I mean, I'm not sure you've looked at the economics of people, you know, with vehicle accidents, and so what the impact is, and if we could influence that, if we could reduce the number of people that feel the need to use substances, how much better our system would be.

**PROF KING:** Can I then (indistinct) your general comments, but we've also made some recommendations, draft recommendations in the area, which I'd like to get your view on. What appears to be one of the most controversial recommendations that we made goes to a social and emotional wellbeing check for children, put as part of their - I think it's their three-year-old or their four-year-old health check, which was directly meant to address many of the issues that you've raise, exposing where a child is having developmental issues, providing support for the family, and if a child is having developmental issues at that stage, the evidence is there, but it will usually reflect a broader family issue.

Now, we've had massive pushback on that, starting from the day our report was released with, you know, what was it? Psych testing for tots - - -

**MS ABRAMSON:** For tots, yes.

**PROF KING:** - - - was the headline in one of the major urban newspapers, and it seems to be that people interpret that sort of recommendation as meaning children will be drugged. How do we move the conversation - how do we - any suggestions for how we need to reframe this debate, because that's not what we mean.

**DR RIESSEN:** Absolutely. I think that it's got to start from the top. I think all these things, there has to be not only the Productivity Commission and the National Mental Health Commission, but it's got to be top of government, top of business, top of education, everywhere. Everyone has to have ownership, and mental health literacy, of course, as we know, you would have seen great variation in it, and so I think, first of all, we - that would be my first step on a plan is to improve mental health literacy right throughout this country, and make sure everyone knows what good mental wellbeing is, and how you achieve it.

And you achieve it through natural - you know, providing support, providing stimulus, providing (indistinct) providing - you know, to children, all the way through. And so that's why the chosen partner of the pregnant lady has to be on board with that as well, and I know that's going to take a generation or two to really nail, but the - I do think you would start, I would start with every service and I would sort of use local government services, I think, as the facilitator of pushing that plan, and yes, but I think that's really important.

And, of course, it should start, as I said, with conception. So you should be able to get it into every pregnant lady and they should all know the importance of maximising not only their own mental wellbeing, and then part of it is all children should then see examples of - and if we could - that's why you need government support. Children at the moment see how our governments behave, how do they learn respect? How do they learn responsibility? You know, I think we need to - you know, everyone needs to take ownership of this whole thing.

I mean, we saw the effect of group resilience during the bushfires, and we see it during wars. If we could in some way initiate - you know, and that's why governments are important. If we could somehow initiate a group responsibility, an Australian responsibility to mental wellbeing, then I think we'd be well on the way to decreasing the numbers of people with mental illness, but also improving the wellbeing of others that are below the surface of the water.

**PROF KING:** Yes. So that it sort of - so Aboriginal and Torres Strait Islanders use a term, and it's used clinically as well, of intergenerational trauma. Is it an issue that we've got to get an educational - get the Australian education through the Australian public. The family's at risk, then kids are at risk.

**DR RIESSEN:** That's right.

**PROF KING:** And it's not just physical, it's mental.

**DR RIESSEN:** Indigenous people are a very important group, and glad you're onto it, because, I mean, to me it's the gap. The gap between the elders, which seems to have switched into more the female, usually, in the indigenous people. The gap between them and their young people who are being thrown into our western world, and it's very hard, and we need to keep those young indigenous people closer to their roots and their families, but at the same time, integrate them into all the benefits of the western world, but not letting them lose their important roots.

I'd just like to just quickly say, you know, I had listened to all those transcripts, and I will now - getting back to observing the last 56 years. The influence of the pharmacological industry is driven heavily by psychiatric influence, and enormous money has been put into suicide strategy, and we haven't seen, significantly, the improvements. And I really want to give a plug, before I stop doing my advocating, to - you guys are really maximising your listening to those with lived experience.

Unfortunately, the whole medical system is orientated to people who are big pharmacy, you know, chief psychiatrists, services where, you know, they've got a set program that a lot of other people in them are doing good jobs, but they are not really influencing the development of mental health improvement, or you know, or preventing mental illness, and I think we could listen more to carers who are, in essence, the backbone. If we don't have carers, you look at the economics of carers, it'd be enormous, and so I think you've got to get into really listening to the advice and experience of people with lived experience and to carers, and I think that would be really a significant way forward, and I would like to see that in the plan.

The barriers to change, I think, are that, you know, the current medical pharmacological system, as you would know. But I think, you know, all the evidence from the National Mental Health Commission, community scenes, to your own transcript, to the World Health Organisation publication, all show that we should be increasing the human rights, and we should be listening to consumers and should be gathering that knowledge. The other big thing is the intrusiveness and - of the media and social media.

That is having a fundamental part, big part. People don't get time to adapt. They don't get the time to develop healthy cognisance and behaviour, defence mechanisms, to allow them to cope with all this news. And then, if they see it, you know, on the main screen how our politicians behave, the way other dignitaries behave, you know, I think this can't be underestimated as to why our young people are, on the whole, rebellious, restless, and have less respect. So that's just one thing.

Another thing is, I think, that should be used is we can use that media positively. You know, we can use - get positive messages out, and I would think that was a worthwhile economic thing, is to - for the Productivity Commission to look at social media and get positive messages out. Secondly, there are Acts, good Acts on checking how people's wellbeing is, and they should be used where everyone suspects people are not doing well, and I think that would improve the feedback and that - and just talking on that, in case I'm not through on time, time's going, there's that - with suicide, particularly, it's all - and I think, RU OK - RU OK is a good thing, but if you ask the question, RU OK, then surely you've got a responsibility to follow it up.

**MS ABRAMSON:** Yes. It's the next step with RU OK. Yes.

**DR RIESSEN:** And it has to - and so that (indistinct).

**PROF KING:** Yes.

**DR RIESSEN:** Now the other barrier, I just quickly want to say, in view of the previous speaker, is when I was consulting in general practice and the availability and use of psychotherapists came up. We all recognise the benefits of psychotherapy. It's fantastic. But how long's a piece of string? I mean, they were first offered one to six appointments. Everyone used six. And then they would apply for another six, and they would use those

six. And not only that, on a whole, there was poor feedback to the GPs. No good protocols for management, and so I think the - I am just concerned.

All I am is expressing a concern, having recognised the benefit of psychotherapy. Everyone could do with checking, to a mentor, to somebody - is the - what this is going to do economically, and I - there's got to be controls and there's got to be good feedback and protocols that accompany it, and so I would just like to make you aware, particularly if you're going to now think of the NDIS along similar lines, then I think there will be a blowout. There'll be an economic blowout with psychotherapy, and I know it's important, and that's what I did in general practice myself.

I'm all for, you know, improving outcomes, but it's - I just see it as a dilemma that you have to confront.

**PROF KING:** Yes. So we've got some draft recommendations around the MBS funded services, because there is no evaluation of the consumers in general. There's certainly no requirement on the psychologists or the person finding the therapy to ask the consumers and get feedback, and there's - the feedback to GPs is pretty perfunctory.

**DR RIESSEN:** I think there's got to be individual responsibility by the consumer. I think there's got to be a responsibility by the GP. There's got to be responsibility by the psychotherapist, and the - no government has a bottomless pit of money.

**MS ABRAMSON:** No.

**PROF KING:** Can I just ask you, because I want to ask one question, but we will have to wind it up. You're a retired GP. You've mentioned the issue on - with the counsellors and so on. One of the things that's been brought to our attention is things like - and you mentioned the incentives and the drug companies. So, for example, GPs and the prescribing of antidepressants has been raised to us as a significant issue. But it's been put to us that, well, consumers go into the GP if they're not feeling well. Do you expect a script? Do you expect a medicine at the end of it? That's what Australians expect out of a GP, so they're just responding to what the consumer wants. How do we change that cycle? How do we break that cycle?

**DR RIESSEN:** Okay. Well, that's got to start with medical training, medical courses, and I think you should - I would be advocating down the track looking at a specific mental health GP specific course, or such. I think the (indistinct) with mental health, I don't think it goes well with money. I think people almost should be on a set wage. You know, and I think that, you know, the time scenario. You know, you've got to have - be flexible, and you've got to have plenty of time. It's no good if someone's really got something on their mind, but it took a little while to be confident with you, or whatever, it's - let them release it, but you've got to be alert to it.

And if you're really booked out the next two days, you know, it's very hard. I mean, I think the whole - that whole thing needs to be addressed, and I think in my 31 pages to -



sorry about that, but the - - -

**MS ABRAMSON:** No, that's fine; 31 is fine.

**DR RIESSEN:** Good. I did address that sort of issue. But finally, my big other final dilemma is plans. When I heard of the 2030 plan, I went, oh god, I could be dead. And I know, if you look at the history of plans and governments, plans get, you know, set aside, recycled, reviewed, and I - you know, and the one thing I'd like to add, you've got to have achievable plans, and I would like think, and I just tongue in cheek, I wrote down, for instance, if by the end of 2020, all members of parliament had a full knowledge of what mental illness and what the influence of mental wellbeing is.

Further, there should be good bipartisan agreement in trying to ensure to optimal parliamentary behaviour and transference on all fronts. Because I am concerned of just what that (indistinct) does. By the end of 2020, all Australians should know not to stop when just asking RU OK, but to absorb the responsibility to follow through to full mental wellbeing. By the end of 21, Australians will know the importance of - all Australians will know the importance of maintaining good mental health and wellbeing, and accept greater personal responsibility for this.

And by the end of 21, significant progress will be made from the Productivity Commission and the National Mental Health Commission with those with lived experience. By the end of 22, all women will be supported from conception to optimise their mental wellbeing, by good local government initiatives, and engaging their chosen partner to fully support. By the end of 22, also all child medical and health encounters will include assessments of wellbeing.

And by the end of 23, all stages in the education process will strongly advocate mental wellbeing at all times, teaching the dangers of substance abuse to the immature brain. Teaching will increase respect, increase personal responsibility, and increase resilience. I just gave an example of achievable plans.

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

**MS ABRAMSON:** Thank you.

**PROF KING:** Next, we have Paul Creedon. Good morning, Mr Creedon. If you're able to just state your name, any organisation your represent, and any opening comments.

**MR CREEDON:** Sure. My name is Paul Creedon from Skylight Mental Health. I will talk, if I can, a little bit about what Skylight Mental Health is, and then talk about some of the key issues from our perspective. I will also leave copies of my - over here so that you can go through that later, if you wish. Just to give a bit of a background about Skylight Mental Health. Skylight Mental Health is an organisation which was created by carers in 1983 as the Schizophrenia Fellowship of South Australia; 2002 it became the Mental Illness Fellowship of South Australia; 2006 it merged with the Mood Disorders

Association in South Australia, and late last year we changed our name formally to Skylight Mental Health.

We're essentially a provider of a range of psychosocial and community-based services for people with primarily a diagnosed mental illness. Not every one of our participants has a diagnosed mental illness, but all would be in the more severe assisted end of experience in terms of mental health. We currently operate across metro and country South Australia, with nine sites across the state, and we believe very strongly that mental illness shouldn't define someone. We value youth experience of peer led programs, and we use those to enhance recovery, personal recovery in particular, wellbeing and strength and resilience.

We value understanding connection, optimism, and courage in our work, and our interactions with service participants and community generally reflect those sorts of values. Our vision is a broad one. It's a vision for South Australian community which understands mental illness and responds with confidence, respect, and hope, and our mission is to increase opportunities to achieve good mental health, to promote acceptance of mental illness in the community, and provide quality services to people with mental illness, their family, and friends.

Last year, we supported well over 2,000 people in a variety of services and programs, including one-on-one support, group skills development and activity programs, counselling, NDIS information sessions, NDIS services, support coordination and support facilitation, short holiday breaks, carers' supports, and carers' information services. All of those services are provided free of charge to consumers, primarily with various state and federal income, as well as NDIS contracts.

Importantly, given the last speakers' comments on lived experienced, annually at Skylight we do a survey of staff satisfaction as well as consumer satisfaction in the organisation, and our most recent staff satisfaction survey, which was in October of last year, showed 78 per cent of our staff reporting a lived experience of mental illness, or of being carers of someone with a serious mental illness. Skylight Mental Health is also an active member of MIFA, the Mental Illness Fellowship of Australia; South Australian member, and many of the points that I'll talk about here are reflected in the detailed MIFA submission to the Productivity Commission's draft report. So I've got a copy of that that I'll give to you as well.

Let's just reflect, if we can, for a moment on the numbers, and these are numbers from the Commission, so you know them well. Almost four million people of all ages experience mental illness each year. Around 690,000 of that group will have severe and ongoing mental health issues. Around 290,000 of that group will require some level of psychosocial community support and rehabilitation each year, and it's likely that most members of that group of 690,000 will require some level of support at some point in their life. Even though many of them will get through with minimal levels of support, some will require significant support.

In the draft report, the number of people with complex care needs is noted as totalling 350,000 people, of which 190 to 250,000 people have episodic or persistent, severe mental illness and have significant complex needs arising from that illness. Despite this, modelling from the NDIS estimates that 64,000 people will be eligible for the NDIS. That's between 25 and 33 per cent of the group that are identified as needing something. We know that the NDIS, at this stage, is only tracking at about half that number. So perhaps as few as 12 per cent of people in South Australia who've - in Australia who require that level of service are getting it through the NDIS.

We do know that there is lots of variation between states and territories and Commonwealth funding, but we do know that the federal government is funding continuative support and national psychosocial support measure, which support perhaps another 13,000 people across Australia, and there are perhaps another 20,000 people across Australia who are receiving supports via some - or one or other of the state or territory funded psychosocial programs. So we know that perhaps 26 to 34 per cent of people with significant complex needs are receiving the psychosocial supports that they require, and so there are two or three times that number who are just not getting access.

**MS ABRAMSON:** Sorry, was that 24 to 36 per cent?

**MR CREEDON:** Per cent.

**MS ABRAMSON:** Yes.

**MR CREEDON:** 34 per cent, sorry. I can't read my own writing. (Indistinct).

**MS ABRAMSON:** So those are the people that are getting support?

**MR CREEDON:** That's right.

**MS ABRAMSON:** Yes.

**MR CREEDON:** And are potentially getting.

**MS ABRAMSON:** Yes.

**MR CREEDON:** We have a, and you would know, very fluid system in terms of - and I'll talk about this in a minute - the definition of what psychosocial support is, and the value of it, is applied differently not just in different states, but in different towns and in different regions, and it's one of the things that I'll talk about in a moment.

**MS ABRAMSON:** And we'll have some questions for you on that, thanks.

**MR CREEDON:** Please, please. So, let me look firstly at what psychosocial services are. It's, I guess, our view that psychosocial services didn't receive enough attention in the draft report, given what we believe that it can achieve. It was mentioned certainly,

but it was mentioned as an adjunct clinical service, rather than - - -

**MS ABRAMSON:** That's a good point, and can I just - I know I'm interrupting you, but we understand that and we've got some questions about can we actually do that a bit better.

**MR CREEDON:** Okay. That would be great.

**MS ABRAMSON:** We understand.

**MR CREEDON:** If you like then, I'll sort of just - - -

**MS ABRAMSON:** That would be really helpful.

**MR CREEDON:** - - - (indistinct) rather than going through as much detail as I had intended. I guess we need to understand that psychosocial support has a significant impact on people's lives at a personal level, at an interpersonal level, so their relationship with other people, but at a community level as well, because it helps reconnect people not just with themselves, but with the people that surround them, and the general community. It has a significant impact in that regard. It strongly links to a concept of recovery, the concept of personal recovery, or as the previous speaker, he mentioned the words human rights, and I think that's where a lot of the mental health sector is now starting to talk about human rights rather than recovery services. The focus being on if you are a human being you have rights to free speech, you have a right to communication, you have a right to proper care, you have a right to proper services that are going to help you achieve the things that you would like to achieve in life, the same as any other people.

That kind of overrules, if you like, trumps the idea of recovery, because it assumes recovery is a part of your human rights, something that you're entitled to.

Consumers frequently report that recovery services are more critical to them in terms of their recovery than clinical services, and there are lots of examples. In South Australia, as I'm sure in other states, of SA Health reviewed services, the Individual Psychosocial Rehabilitation Support Service, the Individual Home Based Support Service and the GP Access Programs, which have all demonstrated that those psychosocial programs prevent people from becoming unwell and then needing to access more extreme clinical services or hospital emergency departments. So the savings there are quite clear, I think.

The difficulty I think for health services is just because there's less demand from beds doesn't mean you can take the beds out of the system.

**MS ABRAMSON:** We're right across that.

**MR CREEDON:** I'm sure you are. This leads us I guess to the concept of the stepping up and stepping down model, and it's a model that in the main the mental health sector is familiar with, but if we use that analogy – it's not a complete model, but if we use that

analogy of stepping up and stepping down, we imagine a staircase, and it's got a similar sort of visual to it, and in that visual, psychosocial services are the handrail that help people step up and step down. They're the thing that keeps everything stable and allows people to pass that point.

**MS ABRAMSON:** I like that very much.

**MR CREEDON:** To just hang on to while they're working stuff out. So it doesn't matter whether they're stepping up or stepping down or just staying where they are at the moment, because where I am is just okay, that handrail is a thing that keeps them safe at that point in time. I guess that's the value for me at a gut level of what psychosocial services do, and that's the stuff that the consumers at Skylight, and in my previous roles, have talked about on a fairly consistent basis, "That's the thing that kept me safe".

**MS ABRAMSON:** Mr Creedon, one of our difficulties, if you don't mind me taking - - -

**MR CREEDON:** Go ahead.

**MS ABRAMSON:** One of our difficulties has been when we represented the stepped care model, in a graph sense it gave too much of an emphasis to the clinical. It's not what we intended to do, and we're, to be honest, struggling to work out what it would look like and we've had various things presented to us, that showed that actually we get that, we get that psychosocial really matters, but the diagrammatic representation for us has been difficult, so any thoughts on that would be welcome.

The other thing aligned with that is that one of the ways that psychosocial supports are made available by government of course is when there's diagnosis. So we're also struggling, to be honest, with well, how can you make the supports available without having some reference point, because that's just how governments deliver programs. So I know I've interrupted you, but that would be really helpful.

**MR CREEDON:** No, no, it gives good direction, because I'd like to say they don't always do that. If we look at that, and using South Australia as an example, the state-funded mental health services is an incredibly direct link between clinical services and psychosocial services. The vast majority of psychosocial services you can't access unless you are receiving a clinical service.

**MS ABRAMSON:** Yes.

**MR CREEDON:** The contrast to that is the Federal Government's previous program the Personal Helpers and Mentors Service, which, now de-funded, did not require a diagnosis. The NDIS does not require a diagnosis – sorry, the NDIS struggles with that intellectually, but the paperwork for the NDIS does not require a diagnosis, it requires a pattern, a history, a way of demonstrating there has been a significant issue.

That's the model that I think works best. Because what it allows people to do is come back into a psychosocial program as and when they need a service, rather than having to go through a clinical gatekeeping program.

Again in South Australia, for a number of years there's been lots and lots of debate around how we could break down the barriers between that nexus, break down that nexus between clinical and psychosocial. And there has been a general comfort amongst clinicians about breaking that down.

The discomfort is not the clinicians, it's the funders. So the funders struggle with how do we measure outcomes – they struggle with that now, but they struggle even more when you take away the diagnosis part of it. Because the question is often asked – and so I use the examples of the GP Access and the Individual Psychosocial Rehabilitation Service – the GP Access Program is a program specific to one of your speakers later on today, UnitingSA, that one you don't need a diagnosis, the individual psychosocial you do need a diagnosis. They produce exactly the same result, they have exactly the same target groups, so there is no logical reason for it.

It is really one of what governments have been trying to do to ration services, knowing there's this massive demand, yet this very small bucket of money.

I guess it makes it easier to give it away if you can actually use an example like you don't actually have a diagnosis. We know, despite that, that diagnosis in terms of mental illness is not very stable.

**MS ABRAMSON:** It changes. We've had a lot of evidence from people.

**MR CREEDON:** Yes. And there are lots and lots of people that providers in the area have come across who very clearly exhibit mental illness behaviours but have never been diagnosed, they've managed to stay out of the system for many years, they've been guarded or protected by family, they've lived on the streets et cetera. And to assume that that group don't have function within this is a ludicrous concept.

**PROF KING:** Can I just follow up on what you said there, because whilst it would be great if governments integration services, we know they will, because they have budgets, and it's an issue – if you don't have a diagnosis doorway for psychosocial supports, and I take completely on board that it's not a very good doorway – a great piece I was reading on the weekend – which I can't remember if it was a paper from one of the journals or one of the submissions, so apologies if someone in this room wrote it – but a comment just providing the evidence that actually if you don't do a diagnosis as the first step, but in fact you treat what's going on and worry about diagnosis down the track, actually the outcomes appear to be better, rather than you try and box people up front, which is interesting from a clinical perspective.

But if you don't use a diagnosis at the doorway, how do – the government will want to ration – okay, so I'll give an example. So say if somebody, this is a real example that was

put to us – somebody who’s got a hoarding disorder, they’re functioning perfectly well in the community, they’re holding down a job, but they’re about to lose their house because of their hoarding disorder, they’ve failed a number of rental inspections, how does that person get the housing support they need? They don’t need clinical support, they need housing support. But how then do they get on the radar, what’s the doorway, what’s the gateway, and how do we convince the government that they’re not going to have everybody running through the gateway?

**MR CREEDON:** It’s a very good question. Part of the issue is that we’ve created a system where you have to be in crisis before you can get any support. So we’ve actually shuttered off an entire community, saying you don’t need support, you don’t need anything because you’re not committing suicide or attempting to commit suicide at this moment in time.

What you’re talking about is there should be multiple entry points depending on your particular needs. So we have in some ways that, if you go to your GP you get access to a counselling service if that’s the appropriate service. That’s one entry point into the system, but there is nothing between there and a suicide attempt.

**PROF KING:** Indeed.

**MR CREEDON:** So there needs to be multiple entry points and people being able to move in and out of systems as and when they need it. We have a system approach which says that you are unwell, we have to medicate you and make you better, and then you leave the system. It’s actually not acknowledging that many of the issues are actually community social issues and where we’ve traditionally had services in Australia which would be called community services, as opposed to mental health services, which actually assist people to manage in the community and to develop and maintain safe households to actually interact with children and other children in the area affected.

All of those sorts of things were built into our service structure in the past and they have all been taken out of our service structure, so that the only way to get support is for this particular person to be identified as having a mental illness.

**MS ABRAMSON:** Could you expand a bit on that for me? I’m really interested in – you said “That used to be there”, what did it look like?

**MR CREEDON:** Community services, there were lots of community centres, there were lots of drop in centres for people in the community. They’ve largely been de-funded over the last 20 or so years. We used to have lots of community organisations and non-government organisations who did parenting classes, who did support groups, who did interactive, who did reach out into the community. They’ve all been de-funded over the last 20 or so years – all is an extreme statement – many of them have been diminished at least over the last many years.

So we’ve shuffled everything that would be seen as a community issue into this area of mental health and we have – and part of what I’ll talk about if we get a chance in a minute

is about the way we misuse the language about mental illness, mental health and wellbeing to mean the same thing, when they're quite distinct categories.

**MS ABRAMSON:** I'm interested in hearing about that, and also when you're talking about that, a lot of people have spoken to us about the recovery model. So in that language, we'd be interested in your views.

**MR CREEDON:** It's a curly one, and if I can take off my mental health hat and put on my disability hat, from a previous life, where I worked in disability for many years and was very active in the community consumer movement. The term "disability" is one that is generally accepted by people in the disability community. They accept it because they chose it. In the area of mental health, people with mental illness didn't get to choose any of this, this has all been applied by other government organisations or funders to make it fit their definition.

So my experience is that most people who have a mental illness are comfortable with the word "mental illness", they get confused about having mental health, because we rarely talk about mental health when we actually mean mental health. We usually talk about mental health when we talk about being sick. It's kind of like we don't talk about heart health when we mean heart disease; we talk about heart disease. So we separate those things out.

So I don't think there's ever been anything that's ever asked people that have experienced what phrase would you prefer, but my experience is that most of the consumers that come to Skylight, or in my previous life came to our services at UnitingSA, would have talked about them having mental illness.

**MS ABRAMSON:** Yes, we did get some commentary around our use of the terms "mental ill health", and to be honest, Mr Creedon, we ourselves were trying to find the right language to use.

**MR CREEDON:** Interestingly, I think that since the words "psychosocial disability" have become a bit more popular around the NDIS, agencies are leaping to that particular phrase. But I think that's as much about it gives legitimacy to the target group as much as anything else, because it was used or brought in – it's been used by the World Health Organisation for some years, but its first appearance in Australia was around the NDIS, it's now become the term used for anyone who might well have a mental illness, so it's become this catchall phrase.

Perhaps that's because we've never asked consumers what they think the right word is, and pretty much every word is ugly, it has a whole lot of connotations around negativity rather than positivity.

**MS ABRAMSON:** Yes, certainly people have spoken to us about the recovery model.



**MR CREEDON:** Yes, and the recovery model, and again we need to separate out the personal recovery from clinical recovery.

**MS ABRAMSON:** Yes.

**MR CREEDON:** So clinical recovery is did you get the right drugs, whereas the personal recovery is are you doing okay as a person.

**MS ABRAMSON:** Yes, can you function in your community.

**MR CREEDON:** Yes, and are you doing the things that you want to do and achieve. And we would argue that term, terminology, is now being corrupted as well, and that's because it's being used in a clinical framework to define you've got the right medication, rather than as a human being you're doing okay. So that's what we're arguing from a consumer perspective at the moment, that the human rights perspective is a more appropriate way of looking at it.

In my own organisation, Skylight, what we do is we don't talk so much about mental illness, we talk about people and we talk about people who come in. The only ones we actually define are staff. So they have a name, they're staff, but everyone else is people, and we try and break down some of the barriers just using simple language like that.

**PROF KING:** Just wary of the time, so any final?

**MR CREEDON:** Look, the rest of it is in here, many of the other things are covered in the MIFA submission, so I won't go so much into those. I do talk about the words like recovery, personal recovery et cetera, and there are a number of recommendations on the back page, but there are also the recommendations that were made by the MIFA submission, so I won't need to go into that.

**PROF KING:** Fantastic.

**MS ABRAMSON:** Mr Creedon, we might – if you could leave your details, I think the staff have them, I would like to follow you up on some of this conversation about language and thank you very much.

**MR CREEDON:** No problem at all.

**PROF KING:** Thank you very much. Next we have Dr Benjamin. Welcome, Dr Benjamin. If you could state your name, the organisation you represent, for the transcript, and any opening comments. I do note that we do have both your pre-draft and post-draft submissions.

**DR BENJAMIN:** I do appear to be one (indistinct). My name's Tom Benjamin, thank you for inviting us to this consultation and for paying our respects. I'm a registered psychologist in a medical school lecturer, but today I'm representing the Medical

Consumers Association, founded in 1976 by my University of New South Wales colleague, Dr Erica Bates, who warned way back then, everyone in the community becomes a potential patient in need of preventative psychiatric intervention.

MCA wrote the original patient bill of rights and I personally had been given power similar to a Royal Commissioner under the New South Wales Public Hospitals Act to report to the Mental Health Royal Commission on the topic of deaths and coverups.

Now, our detailed references were submitted, and I'll also submit this transcript, made by PC, and I'd like to give you a handout that you can follow, so I can abbreviate it a bit in this verbal commentary.

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

**PROF KING:** Now, again, just for the transcript, we've received two pages of handout.

**DR BENJAMIN:** Now, these are a summary of consumer protection considerations, I'll just highlight them very quickly. A draft report presenting one fait accompli option is not acceptable. The most important policy option is the no regulation option. Regulation is a last resort. The Australian Competition and Consumer Commission (ACCC) is our principal legislative weapon. Registration of these professions should be removed unless there is overwhelming evidence for retention.

Cartels are immoral and illegal, because they not only cheat consumers, they're destroying other businesses by controlling services to the point where honest and well run companies cannot survive, destroying consumer confidence in an entire sector.

These words should all sound familiar, they're not MCA's words. I just read out to you current government policy that's "intended to be read by every member of the Australian Public Service from the most junior member of the policy team to the departmental secretary", the same ministry that wrote your Terms of Reference.

Now, the proposals in your draft report have resurfaced time and again; 2005, 2011, the results have already been catastrophic. The draft proposal, with all due respect, has potential to make things worse and wreck the economy. Again, these are quotes from others, not MCA. You have many warnings among your hundreds of submissions and your own earlier reports.

For example, in concern that the media had perhaps misinterpreted the idea about the assessment of zero to three year olds, well, the most dire warnings about that sort of thing came from this gentleman, Dr Allen J Francis, who wrote this book, the Diagnostic and Statistical Manual, which we're all familiar with.

He came out of retirement specifically to warn the dangers of diagnostic conflation, over-hype treatment, and drugging very young people. Just this week in my university role I passed around several articles where they were trying Prozac, not on two year olds, but on

one year olds. So it's not a media fantasy, these are warnings from authoritative sources. For example the APS, in your workforce hearings back in 2005, warned that the telepsychiatry movement would just result in a route to drugging.

So again, it's not the media beating these things up, these are warnings – the most dire warnings about bounty hunters in the schools came from the United States Congress, and the quote about wrecking the economy was from Dr Allen J Francis, because the idea that with the stroke of a pen you could create 10 billion patients overnight, has changed one line in this book.

The ACCC calls the health sector a new priority area, but the commissioners have warned that the governments have been reluctant to take strong action, and Commissioner Graeme Samuel said the health minister even told him to back off. So the current minister for health wrote to us at MCA stating he didn't want to burden the ACCC while your inquiry was underway. So it's back off, the ball is in your court.

As a consumer group, our punchline, as in our written submission, is an ACCC inquiry. The evidence now available to the Productivity Commission does not in any way support the \$500 million a day of saving, the proposals are much more likely to wreck the economy.

False psychiatric labels or hundreds of thousands, if not millions, of Australians can create a pill popping, intergenerational underclass of people identifying themselves as having a mental disorder, a get out of work free card. I already see such people in the clinics. Evidence we've submitted points toward suicide rates made worse, higher costs for placebo level treatments, waiting lists, excessive psychiatric labelling, removal of stigma, making the false positive seem acceptable, prescription drug problems, mass unemployability, unsustainable mental health workforce, with no savings from prevented illnesses.

Our solution to all this, the ACCC. Although you have section 52 barring false and misleading evidence, as Lord (indistinct) would have said, "An opinion so arrived differs by the whole winds from the heavens from the decision of a court".

The structure of the mental health sector workforce should be subjected to a full ACCC inquiry. The 2011 Senate inquiry heard identical proposals and concerns; the opposition criticised the inquiry process. Well, they're now the government. The debate was heated, with over a thousand submissions back then.

As for the essence of consumer protection, what it's about. Well, let's just say that we have here expensive water, contaminated water and tap water. Consumers are concerned that if the expensive water turns out to be tap water or has some contaminant that makes it worse than the dodgy water.

Mental health sector is exactly the same; you have here your cults and your illegal drugs. Here you have your expensive, regulated prescription drugs, lobotomies, psychotherapies of all kinds, electroconvulsive treatments and electromagnetic treatments, and here you have your free consults. What if you find that these people get no better results than these?

Who should pay 300 bucks for a glass of tap water? That's a typical consumer question. We need to clarify it.

The evidence doesn't show that mental health treatments don't work, the problem is the opposite. Everything works, including the placebo or doing nothing. There are hundreds of new psychotherapies each year, maybe they work, but so does generic counselling done by unregistered, uncertified, minimally trained unpaid persons. So why pay 300 bucks a glass for tap water or a sugar pill?

The statistic common in journal articles will hail the treatment as being successful if it has an NNT as low as four. Now, NNT is the number needed to treat, refers to the number of people who would need to be exposed to the treatment for one to benefit. Let's imagine this in dentistry.

Clint Eastwood, the dentist – “I know what you're thinking, I've already drilled three people this morning, one of you will get better. I've got to ask you, are you feeling lucky”  
- - -

**MS ABRAMSON:** You do a very good impersonation of Clint Eastwood, I must say.

**DR BENJAMIN:** And the NNTs in the drug trials are commonly higher than four, sometimes as high as 9 FFD, so as a consumer group, what we're asking is who speaks for the other eight persons. With this idea that one out of two people has a mental health history, submissions to your Commission said that the real figure might be more like the traditional three per cent who have a serious mental illness condition.

Of course, the kind of people who are going to come to an inquiry hearing will be those who care for or are concerned with the three per cent. Our question, as Medical Consumers Groups, who's speaking for the other 97 per cent? And if I'm in my clinic this afternoon seeing somebody who walks in and I think, “Well, actually they're in the 97 per cent, I don't want to run a mental health treatment plan on them because it gives them a label”. To save a few bucks, people will take these labels.

With childhood detection it becomes even scarier, because the Commission has been told it's difficult to predict specific psychiatric conditions in the teenager. Sure, you can look at a family and say, oh, there's likely to be some problem here. Sure, any of us can do that. Try to predict which psychiatric condition that they'll have at age 30, we know that you can't even do it at age 18, and now we're saying we can do it as soon as they're born.

The agensis a decade from now will walk in here and testify we used to be assigning the label before they're born, but they'll have no say in it. The other kids in the schoolyard will, because when they find out that they have this mental health illness label, this risk label, in reducing the stigma only makes it credible. I know the label sticks because I've had to, as an expert witness, defend people in court who – not defend them, but people who have a motor vehicle accident and they'll try to come up with a reason to give them a psychiatric label. Could be something they did in school, like they missed a day of school

or something like that. The label sticks, yet it also appears to their unborn children because it becomes family history of mental illness.

I've even seen it where patient said – I said, “Well, why do you have this mental illness thing in your record”, and they said, “I think a cousin had ADHD. I think a cousin had ADHD”. That passed through three reports and ended up being “History of mental illness”, to squash the insurance claim. It goes on every day.

Now, the two tier stepped care system is basically a caste system. It sounds logical that you should have advanced skills to treat extreme conditions, but that's general medicine. It's never been shown to apply in the mental health sector. The submissions show there's no evidence for difference in outcomes in any mental health conditions attributable to training, and the training is costly, up to \$30,000 a year for reports. It's always been a closed shop.

Back in 1963 we read that there were 50 applicants for eight places, and the evidence now is that it has not and never will improve, they'll never have enough places to train all these people, and there's no reason to. The evidence for decades has shown that psychotherapies don't beat each other, or placebo. The main damage of the stepped care category is confusion. When a referral walks through my door I've got no way of predicting that they might be classed as moderate to severe. So what if I think they're one of the 97 per cent who don't have a serious mental illness. It might fear I'll get in trouble with AHPRA for refusing to treat or I'm supposedly exceeding our skill level.

And the poor GP is in a similar position, they get paid more to write a mental health treatment plan than I do to carry out the treatment, but they risk an audit if they refer it to the general allied health practitioner or a counsellor. So their safe default is to give them a psychiatric label for life, refer them to the clinical psychologist and psychiatrist, irrespective of waiting lists, high price, psychiatric labels, placebo level and drug prescription.

Does anyone seriously think I'd sit in a clinic unpaid to act as a referral agent passing people on to the waiting lists of my colleagues? No, I will close shop. That's not a prediction, that's my own experience. I was offering bulk-billed services in a regional and rural area, we were also an indigenous clinic, I closed the two practices to move here to Coffs Harbour to take up a position.

The town I left behind is now surrounded by bushfires, I can't help them. The town is ineligible for general psych teleservice. Before leaving I recruited volunteers who were highly qualified, one with a PhD, who would have been quite happy to replace me in the role, they've been working for free and they would have charged little more than the gap fees.

Thanks to the AHPRA requirements, they remain unregistered. Some are in fact unemployed, and they've left the mental health sector. So I doubt that I will be replaceable.

So government money, for who? I'm told that the ECT machine is running hot and there's a queue for it. That's your mental health service.

Our clinic here in Adelaide is the same. We have a highly trained psychotherapist counsellor, she's not had a single referral. I get referrals because I'm registered with Medicare. I rang Medicare and they advised me it would be illegal for me to pass that other 97 per cent patient on to the counsellor. So this afternoon I've got patients on the book to see, she has none. Unsustainable.

And you were warned back in 2011 – sorry, the Senate was warned – that many patients have little choice but to use the funded, hence cheaper, less well trained practitioner. That was a warning from the APS. And your own 2005 workforce report said the skills of many health workers are not being utilised to full advantage because of systemic impediments.

So just pushing on because of time - - -

**PROF KING:** Yes, we're aware of the time, and I do want to ask you some questions.

**DR BENJAMIN:** No, that's fine. Our recommendation is that this entire mental health workforce edifice should have presented its case for existence to the ACCC. The ACCC Commissioners have called for it, it's the law, it's long overdue. And the Minister of the Commissioner of you has warned, there are a relatively small number of situations that justify direct government intervention.

**PROF KING:** Thank you very much. On the ACCC one - - -

**MS ABRAMSON:** The former Commissioner.

**PROF KING:** I used to be an ACCC Commissioner.

**DR BENJAMIN:** Okay, all right.

**PROF KING:** That unfortunately, they don't have jurisdiction over the colleges, which is something we found out when we were trying to move some things. You suggested - - -

**DR BENJAMIN:** The Royal College of Surgeons actually had to make an application to the ACCC, they did.

**PROF KING:** The formerly – there's various practices that have to be authorised by the Commission, I'm not sure if the General College of Surgeons, but the actual restrictive practices that – I shouldn't be judgmental – the practices of the colleges in terms of registration, my understanding is they're actually outside the Act. But that doesn't mean the government couldn't refer to them.

**DR BENJAMIN:** My understanding is that they could, and they actually submitted, and I'm saying that these other bodies should do so, because I think they'll be empty handed if

the onus of proof – see, the difference is, with all due respect, I’m not going to be cross-examined, you’re only going to ask me some questions. But - - -

**MS ABRAMSON:** We can if you’d like us to.

**DR BENJAMIN:** No, no - - -

**MS ABRAMSON:** I am a trained lawyer.

**DR BENJAMIN:** Well, I might consult over here, you can’t cross-examine them.

**MS ABRAMSON:** I understand.

**DR BENJAMIN:** And the thing is, I can’t cross-examine people who might have made up lies about me, as happened in the Royal Commission in New South Wales. The Department of Health complained about the report into the psychosurgery, I had no way of knowing what they said, couldn’t defend myself, and what about the dead patients?

**PROF KING:** Sorry, I took us off track, which I shouldn’t do, but I have a tendency to. Take on board everything you’re saying about the early childhood wellbeing change. This faces us with a dilemma, or I see it as a dilemma, I want to understand from you if you see it as a dilemma or something that we just don’t need to go near. So my understanding of the evidence is that there is significant evidence of early childhood trauma, issues of attachment, families that are struggling, will affect the children and will affect the development of those children, will affect their success in later life.

**DR BENJAMIN:** Well, I think that - - -

**PROF KING:** Is that wrong?

**DR BENJAMIN:** Would you like an analogy?

**PROF KING:** Yes, please.

**DR BENJAMIN:** If you take Serena Williams and trace her back, you could probably say that at age 2 she was showing signs that she could become a good athlete. That doesn’t tell you it’s going to be tennis.

**PROF KING:** No, no, that’s right.

**DR BENJAMIN:** She could have become a pianist. And what I’m saying is that I have no doubt, and psychologists say this all the time, one can easily – and so can I, I can just look at somebody and smell them and tell them this family has got some big problems. Well, no issue there. The issue is you can’t predict something that’s going to happen when they’re 30 years old and the boss makes a pass at them and, you know - - -

**PROF KING:** Agree entirely, yes.

**DR BENJAMIN:** And it's a totally different condition, and the submission here was saying that it was someone has experienced psychosis, they can't even predict that at age 18. And I'm thinking, well, what can you really tell about kids that are in trouble that the schools don't already know. I remember – look, I was also a bureaucrat in the Department of Education for 10 years, and whenever I put proposals up they just laughed, because they said, “We know all this stuff”.

**PROF KING:** So schools is what – we're actually talking before you get to school. So agree that teachers in schools know what's going on.

**DR BENJAMIN:** Let me put it not in my words, because I'm not an expert on this. Allen J Francis cautioned that whatever they say they're going to do, it ends up with drugs, that's basically - - -

**PROF KING:** Okay, so that's really my question. How do we – because my understanding is there's no need for diagnosis, and certainly not at that age, and there's - - -

**DR BENJAMIN:** Too early. And the therapies – the other question is, what is the therapy here? Therapies are play therapy. Now, do you need a \$300 an hour gap fee psychiatrist to do play therapy or could you just use some community worker?

**PROF KING:** But that's not what we suggest. So we're suggesting through the health check, to get the help back to families.

**DR BENJAMIN:** What I see is what's the help, that's my - - -

**PROF KING:** I see. We need to be clear on that, okay.

**DR BENJAMIN:** It's not the fact that the kid is at risk, that's not an issue. I can spot that. What I'm saying is okay, who's the help? Is the help going to be a \$300 an hour person with a gap and a waiting list, and as I said, back in Coffs Harbour where I live, that's what they've got, gap fees, waiting lists and an ECT machine. I've not been replaced, and yet there are people sitting there with PhDs who are ready to roll in and replace. Can't do it, thanks to AHPRA.

You'll find the same thing with the zero to three year olds. They'll say, oh, this kid's at risk. Unfortunately they'll have to drive a hundred miles to join a waiting list and get on the list scheme, and then somebody will come along and say, ah, I've got Prozac.

**PROF KING:** Okay, so we need to be much clearer that what we're meaning by then the follow up is the psychosocial health care for family and support for the family.

**DR BENJAMIN:** Yes, exactly.



**PROF KING:** Okay, take on board, yes.

**DR BENJAMIN:** And the history needed so we'll get a view, and the reason I've submitted in my written thing, the US Congress hearing called the – profits of misery. Major problems in Texas they had, they had a Senate inquiry. Because what happened was the school counsellors were being used as spotters for bounty hunters to come into the school, get a uniformed official to go to the kid's house, drag them off to the psychiatric hospital, run up a bill for 28 days and then discharge them with a psychiatric label for life.

And the evidence was that there was one psychiatrist who had been ticking these off, and another psychiatrist testified, he said, "Here they offer me an extra 300 grand a year to tick those boxes". Had it not been for that expose, we would have had that here. Why do I say that? Because Four Corners did an expose on it, and the New South Wales Health Department tried to block the ABC from showing it. They did show it, and every parliament in every state here said, hey, we don't want that here.

That was the National Medical Enterprises scandal of 1992, which I've submitted to you.

**PROF KING:** Yes. Okay.

**DR BENJAMIN:** So my point is that these things always get abused, the history is there that they get abused, and whatever your good intent will be sabotaged by a lot of big funded interests - - -

**PROF KING:** And just to take it a step further. Your view, and this is reflected in your submission, is they can't be designed not to be abused. That's where I have the fundamental problem.

**DR BENJAMIN:** The history is what it is - - -

**PROF KING:** Yes, I know.

**DR BENJAMIN:** Like are we ever going to have another war. I suspect we will, because we keep trying to stop war, we all know it's bad for us, and yet, every year they go.

**PROF KING:** Yes, I guess - - -

**DR BENJAMIN:** I remember Thomas Sasse came out once here, gave a talk, and they asked him, they said, "What would you do about it", and he said, "I'd need the powers of Jesus, Mohammed and Buddha together to make a dent in the medical profession", and I think you'll find that that's the problem. It is big bucks, and the government's constantly under pressure to do something. That's why I've quoted these. If you really need to say, look, this is too much of a mess, quote it back. That's Josh Frydenberg there who wrote your Terms of Reference, saying your best important policy option is don't do it.

**PROF KING:** And an important lesson for us – I think we need to be careful against who. So we're reading your submissions, listening to your testimony, my reaction is, ah yes, but we can come up with a system that won't be abused. And I think your real message to us is make sure we don't get caught up in our hubris.

**DR BENJAMIN:** Yes, and think about the ACCC, because I don't think that they're barred from looking into it. The thing is, I have actually written just this last month a lengthy submission to them reporting certain funding associations as cartels, because it says in the law cartels are illegal and immoral. I showed why these are cartels and why they are in fact disrupting the market.

You heard from the counsellors this morning, about Ms Dawson, and I've got to face it this afternoon, the council is paying for the rooms too, there's no referrals, they won't get any, because I get them because I'm under Medicare. But I don't particularly want to do them all.

**PROF KING:** Okay, thank you for that. And that has clarified, from at least my perspective, those are your submissions and I understand your position better. Thank you very much.

**DR BENJAMIN:** Sure, thank you.

**PROF KING:** Some morning tea won't be there at the moment or it is there. Is the morning tea there, because we need bathroom breaks. Let's just take 10 minutes now for a quick morning tea and a bathroom break.

**SHORT ADJOURNMENT**

**10.59 am**

**RESUMED**

**11.10 am**

**PROF KING:** All right, so we'll get started again, and Mr Fornarino, if you would be able to state your name, any organisation you represent for the transcript, and any opening comments you'd like to make.

**MR FORNARINO:** My name is Aaron Fornarino. I'm a public sector worker for the South Australian government, a final year law student studying here in (indistinct), and I'm also a Facebook administrator for a group called Borderline (Indistinct) on Facebook. So that's a bit about me. I'm here representing myself in a private capacity, I would say. I submitted a written document back in February 2019 (indistinct) to the mental health condition Borderline Personality Disorder. I was diagnosed with BPD, as I'll call it for short, when I was 14. I had a long range of hospital admissions and different medications that I was put on. I used to engage in self-harm a lot. I still have scarring from that, and it's been a very trying time to get where I am now.

I'm incredibly happy I've almost completed a law degree. It hasn't been easy, on top of working full-time, so - but my passion lies also in mental health advocacy and bringing light to Borderline Personality Disorder, which was - thought it was wastebasket diagnosis when I was quite young, and we were often called beyond help and attention seeking and manipulative and all sorts of names. This was by the mental health profession itself, police and ambulance workers. It was very, very difficult to live with that, and that was just me, it wasn't my friends or my family. That's not taking into account all the misinformation they were given about BPD at the time. There wasn't much known, whereas treatment initiatives have advanced quite a lot over the last decade I've noticed, which is great.

There's more services available but they're all full - at capacity. So, I wanted to discuss just briefly an administrative matter with the report that I noticed in volume 2, page 804.

**MS ABRAMSON:** Did we make a typo or misquoted you?

**MR FORNARINO:** I think quoted as saying bipolar disorder instead of borderline.

**MS ABRAMSON:** Our apologies for that.

**PROF KING:** Sorry about that.

**MR FORNARINO:** No, no, that's okay, it's just (indistinct).

**MS ABRAMSON:** No, it's a big report and sometimes these things happen, so our apologies.

**MR FORNARINO:** It is, yes, it is, but - no, no, that's okay. I just wanted to raise that. So, in the submission that I wrote I discuss on early intervention and prevention. What concerns me about schools in particular is that with mental health disorders that they're quite difficult to pick up when you're an adolescent, or they get dismissed quite easily - I know I certainly was - and a lot of problem with school curriculum is that it's rushed, and if you're quite behind or not keeping up the pace it's often dismissed and you go not knowing, or not learning a particular area. That was one issue that stuck with me that I remember from my school years.

So, I struggled in school, but mainly because when I hit adolescence I was in hospital quite a lot. It's just it was impossible to try and study while I've been on all sorts of different psychiatric medications. A lot of these medications have very horrible side effects. I didn't learn of a condition called akathisia until I was quite late and where I had really bad nervous reactions from the medication that was given, and it was dismissed as bad behaviour when it was actually a drug reaction, so that's quite concerning. It's quite rare, so I - if medication works for people that's great, but it didn't for me and I haven't taken medication for quite some years now.

There's a lot of investment by the federal government in youth mental health, particularly towards Headspace. I think Headspace do a fantastic job to a certain degree. I think they focus primarily on depression and anxiety in youth, but a lot of the more complex mental health disorders go ignored or there's not as much support available. That was certainly the case when I was young, and from what I've heard people over, I think it's 24 - so if you're 25 or over you really struggle trying to find treatment options that are quick and can assist you. So, with stigma in general, I read the discrimination section in the report and found that was quite interesting.

I reviewed the study that was quoted; I think it was by Morgan (Indistinct) 2016. It concerned me that what (indistinct) was used, primarily because it claims that 11.8 per cent of the respondents only reported discrimination, but when I reviewed the table that they've outlined - I think it was on page 758 of that article - they've got a weighted table of mental health problems, but the two primary disorders on there are depression and anxiety, including PTSD and OCD, but then there were listed bipolar, psychotic, eating, and personality disorders in (indistinct) minority, but at the same time they've sort of quoted multiple diagnoses were possible.

So, it sort of stuns me a bit that a table like that can be used, but it's not very specific and it makes it look like depression and anxiety are the two biggest factors of what were their study for discrimination, which I don't really agree with because from my experience and from a lot of others who I've talked to with BPD - as I said, I'm a Facebook administrator so I interact with people with BPD quite frequently, and many complained of discrimination and poor treatment, especially in emergency departments, particularly here in South Australia, which is concerning.

**PROF KING:** Sorry, can I - you raised a good point on - and I can't remember the details of the article off the top of my head, so apologies, but there would be an issue if they've done a survey of people with mental health issues, because we know that in terms of prevalence mild anxiety and depression are by far the most common, so it could be quite possible to get their results if you're saying, well, if you can - if you do it over the whole population and you've got - a large part of that population is a group with very low - low or mild intensity and symptoms, so they don't face stigma, but there's another group up here that may 100 per cent face stigma, and you can still end up with a low number simply because you're not focusing on the right group. So, do you think that's a proper way of interpreting what was happening there?

**MR FORNARINO:** Considering personality disorder is last - lastly ranked at 1.2 on the table - I think, yes, it is quite a minority, but a lot of people with personality disorders experience discrimination, and not just BPD. It's a whole range of (indistinct).

**PROF KING:** Yes. No, agreed. So really the issue is that it's not sensible to talk about stigma and discrimination over all mental ill-health. It's necessary to think about a degree of severity.

**MR FORNARINO:** Of severity.

**PROF KING:** And diagnosis, and I want to come back to diagnosis, but apologies, I intervened.

**MR FORNARINO:** No, that's okay. Some other things that have been concerning over the years as I've been growing up looking at how BPD has been treated, is just some attitudes between politicians at federal and state levels. A lot like to football health between one another so to speak, as in it's a state attitude as - sorry, a state issue, like that sort of attitude, whereas you go on the telly, ABC Question Time, and you look at politicians engaging in rather bullying and concerning behaviour but telling teenagers bullying is not okay. That concerns me. It just sends a mixed message that I think is quite wrong.

Peer working has been an interesting area. I work full-time in taxation matters for state and state-based tax, and it's a rewarding job and I enjoy working with the public, but it's (indistinct) and I can earn money through doing my work with the government, but at the same time there's not much incentive for me to go and - I mean, despite a lack of incentive I still do go out and speak about BPD. I've presented at a couple of interstate conferences over the last two years, which has been great. I've engaged in BPD services and offering an opinion, but it - the peer work sector is very poorly funded. For something that's very essential and crucial to assisting people with mental health issues that - I find that sector very competitive and very low paying for how important it is. I would like to see some sort of initiative towards lived experience, which is really important.

This year I attended an interesting session run by a group called Acrofyre. They assist prisoners in their release and transition between prison and back to - back into the community. What I found interesting is that a lot men with BPD are either misdiagnosed or not diagnosed at all, and they receive nothing. It was often in the quotation of 75 to 25, with 75 being women and 25 being men. While that may be statistically correct for those who are diagnosed it doesn't mean by any stretch that men with BPD aren't out there. There's no many services for men. Men have that additional layer of discrimination just by being a man. BPD is considered to be a very - I'm not saying I agree with this, but a very dramatic, sensitive illness and you have men that have been taught to be resilient and to hide your feelings pretty much, which compounds a very big issue, and I wouldn't be surprised if there was a good proportion of men who do commit suicide because they just - they can't get help.

They either don't want to identify they have a problem and they commit suicide, or they attempt to seek treatment and end up committing suicide anyway. I've had several friends over the years that I've lost to suicide. It is really a difficult area. It concerns me a little when I see campaigns talking about suicide prevention, zero targets for suicide, when as I said earlier, depression and anxiety have become more prevalent as mental health disorders and talking and education has come a long way in the last decade at least, but for the more sever type illness they're still taboo, they're still not spoken about very much. That concerns me and it concerns a lot of the people that I've worked - I try to work with.

One thing in particular for me is that I (indistinct) medication didn't work well for me. It does for some but I think there's an over reliance on medication for people with BPD. I met with a community cabinet area in 2011. I met Nicola Roxon under Prime Minister Gillard's government and Mark Butler, I think, was the mental health minister at the time, and I discussed about issues relating to the Better Access to Medicare scheme, or ATAPS I think as it was then, because they've reduced the amount of services provided to people to seek psychological support. I was told pretty much that it was a short-term measure, that the actual Better Access to Medicare scheme was never intended to replace full-blown psychological support, but I was told it was a temporary setback, but here we are in 2019 and the sessions still haven't changed, so it's - I'm not sure what's happening with that.

It's been really rewarding being able to work with people with BPD. From the talks that I've given and the feedback that I've received over the years, the last - because I've only really been doing advocacy work for the last three years. I needed to be in the mind space where I could do it, because it is very demanding and it can be very confronting, but to hear some of the positive feedback that I've received, it's been great. It's just difficult when you get someone that comes to you with a problem and you want to have all the time in the world to listen to them, but the practical reality is you don't. You can't, and it's hard because you don't have many options you can offer either.

It was concerning to see that eating disorders got given a 40 session boost with that access scheme, but ironically many with eating disorders also have BPD, but it shuns men to a certain degree because women are more likely to have eating disorders than men. Not saying they don't happen, but they do. I mean, it still sort of limits - I look at it that you could really kill two birds with one stone if you expanded that 40 session to BPD, not just eating disorders. It would have captured a lot more people and would have been a lot more beneficial.

Just going back a little bit to stigma, many thought BPD was a load of rubbish, a load of nonsense. That's very disheartening if you're diagnosed with that sort of condition because it is very intense. You do self-harm a lot. I've had two serious suicide attempts in my lifetime where I've almost died, and to have someone come along and say "Well, you don't have a mental illness". It's not a mental illness, it's a personality disorder, and then to look at media attitudes towards BPD in particular, and reporting on them when it's usually in the context of criminal offending, where some defendant has used their BPD as trying to receive some sort of mitigation.

There was a recent case in Victoria last year I think where personality disorders were now considered to be a worthy mitigating factor. I'm not really happy with the case that was used for that, because it involved a really graphic murder. I don't think personality disorders should be used as an excuse for acts of violence like that, but at the same time for minor type offences, to get someone on track and in help in therapy mitigation should be used. The role of social media in discussing mental health, with things like Facebook and Twitter and whatnot, are sometimes a really bad platform for discussing these issues.

You get comments from a variety of the public, often calling mental health as bleeding heart defences, particularly with criminal cases; "Oh, they'll just get let off. They'll claim they have a mental health issue when they appear."

It's hard to read stuff like that because mental health really does affect you as a person, and sometimes media only report on one side, which is usually the victim's side, which is fair enough but there's very little reporting on - at all on the offender or their circumstance or their background. I often read sentencing remarks to the courts here, and it's quite interesting, in 2017 I - I often Google BPD just for the sake of it, to see what sort of study is going on or if it's progressed - if anything's progressed, if attitudes have changed, and I came across a court hearing here in South Australia run by the Coroner's Court, and it was over the deaths of two young women who committed suicide from BPD, and their treatment - very poor treatment, I should say - and I actually took time off work and sat in each day to listen to the coroner, and I just found myself shaking my head constantly.

The descriptions of what these two young women went through I identified with very strongly, and it was really upsetting, and the whole reason I went to that hearing is I figured as a law student, if I could sit through something like that, something really personal to me, then I can do anything really. I can - I'll be able to handle anything in that area, but it was really concerning to hear their treatment and just being able to identify with their poor treatment. I've engaged with psychiatrists before I commenced this advocacy work, usually often in a distressed and agitated state where they'd be debating whether BPD was a psychiatric disorder or not, and would use that as a basis to discharge, saying "No, it's not", and that's horrible.

My poor family, I feel sorry for at having to come and pick me up at 2 am from hospital as a teenager because I had nowhere to go. I was discharged and that was it. That's - that was really difficult for them, and being fed all sorts of information like I was just an attention seeker. I read a document from a psychiatrist saying that I could switch my symptoms on and off. It doesn't work like that with BPD, not at all. There are very bad issues with impulsivity, very severe issue with impulsivity that wreak havoc with your decision making abilities, and I think people don't understand that. They think it's a conscious choice to act out and there's no ability to stop - sorry, there's an ability to stop when there isn't. A bit beyond that, so I would like to see more federal funding towards BPD. I don't think it goes far enough, not at all.

I assisted SANE Australia with a peer - sorry, a treatment services report and we were looking at just the general treatment services all over Australia, and it's very poor, very poor if any. You have certain, like, state run services, like Project Air in Sydney, and they do a lot of great work. Brin Grenyer, he heads that, and they really expanded their program over there, and I would consider it very successful, and a few years ago when we had the state election here the ministers from both parties announced a BPD centre for South Australia, which was a great first step, and I think it was a consequence of the coronial inquiry. So that's up and running, but it's still very slow, a very slow process.

It's great to see that there've been advances towards mental health, but at the same time it's incredibly slow, and I think there's a lot of mental health issues and concerns that aren't raised, that are avoided, and there's a lot of focus on depression and anxiety. We're now not the be all and end all of mental illness.

**PROF KING:** Can I ask you - sorry, but can I ask you about the stigma by the medical profession, because we have heard, and indeed not just from people who have lived experience but also from clinicians themselves, that there are psychologists and psychiatrists out there who will not deal with, refuse to deal with, will shunt off anyone with BPD, and I find that concerning. I mean, it's an issue of stigma, and I'm wondering is it getting better, is it getting worse, is it about the same, and I don't know what we can do about it when the actual professionals themselves, who should know better, behave that way.

**MR FORNARINO:** You would think that, that it would have gotten better. I - from some of the stories that I've heard of, being an administrator, it appears on face value not much has changed, if any, particularly when trying to seek help, like trying to seek a psychiatrist and being told "No, I don't work with people with BPD", or something similar like that. I say it hasn't progressed that much. I mean, it is a bit different now because we do have a centre that sort of specialises in that, but at the same time I'm concerned that the centre only deals with very severe cases, rather than just generalised BPD.

**PROF KING:** Yes.

**MR FORNARINO:** Trying to seek help with BPD through a psychiatrist is incredibly tiring. You end up ringing around psychiatrist after psychiatrist hoping to get an appointment. Appointments are often drawn out so you're waiting months, and even DBT services, which are dialectical behavioural therapy, those services have, like, two to four years wait lists, which is crazy, that long to get into that evidence-based treatment. I've done DBT twice. It's really helped me. I was lucky to get in twice when I did, but I did, and for others, watching them wait, it's exhausting.

**PROF KING:** So is that just - sorry, just on - - -

**MR FORNARINO:** And they're trying to - - -

**PROF KING:** Just on that, is it for the - for dialectic - I can never remember the acronyms - this dialectic therapy, is the waiting list issue related to publicly funded or bulk billed services versus services with a significant co-payment, or is there just waiting lists for all services?

**MR FORNARINO:** I think it's both. I think both public and private are maxed out to their capacity.

**PROF KING:** Okay.



**MR FORNARINO:** I know someone recently was looking for private services because they were that desperate, and I attempted to locate one but they advised that they were full, and they couldn't take any more on. So, DBT is very cost effective in terms of ongoing health costs, which has also been an interesting issue over the years, to - we've tried to say to politicians that "Look, if you invest in this area for a modest amount of money you're overall going to reduce your health costs, and not just health but police, ambulance, all those soft services. You can save on costs if you invest in this." That was met with dismissing attitudes when - over a few years ago, when I first started enquiring about this.

It defied all logic that "No, we won't run a BPD centre in South Australia" by some political entities, when finally they have. I'm hoping that they do see a benefit over the long-term, but it is well worth the investment, that you do actually save money by treating this disorder, and it can be treated. You never fully recover from BPD. It's like I still have my bad days. I still - like anyone, and I guess that's what sometimes people don't understand, is that people look at the diagnostic criteria of BPD and go "Well everyone feels like that. Everyone has days where they - that they're up and down and all over the place", and it's like, well yes, but not to the severity of someone with BPD. The emotional intensity of BPD is horrible. It's - you go on very bad mood swings and it's hard for those around you to see that.

It's like with police and ambulance. They deal with you for, I don't know, two or three hours and then they go, and then they don't remember you. They don't see you when you're beyond that distressed state. They don't see that you actually function okay and work, and that is possible, but I just think more education around the overall health sector about BPD is required. There's a lot of bureaucratic red tape and competition as to who can provide those services, which I don't really agree with, but there is definitely more education and treatment that needs to be done in this area, and I think it's only really just scratched the surface, if that makes sense. I don't think it's to its full potential with treatment options yet.

**PROF KING:** Can I just ask one last question from me? Apologies I'm sort of hogging it a bit, but you had a diagnosis in your teenage years. That then led to - that led to a lot of stigma and so on. Was the diagnosis helpful? And this is again coming back to something that you may have heard me mention earlier on, but there does seem to be differing views in the professions about whether a diagnosis is actually helpful or not, and it seems to - my perspective - I'm not a clinician, so it seems very confused from my perspective. Does a diagnosis help? In your case did it help?

**MR FORNARINO:** I'll just touch on the name briefly before answering your query.

**PROF KING:** Yes.

**MR FORNARINO:** The term Borderline Personality Disorder, the first thing that people think of when they hear that term is "Borderline of what? What are you on the

border of?" and then they see personality disorder. There's nothing disordered about my personality. It's just a term that's been thrown together.

**PROF KING:** Yes.

**MR FORNARINO:** A very outdated term, and the substitutes for it aren't too much better, like Emotionally Unstable Personality Disorder. I cannot stand that. That's just as bad as BPD. But me aside, having a diagnosis, for me, I suppose at the time when I was given it - I mean, I was given the term BPD by a very competent and skilled psychiatrist when I was 14.

**PROF KING:** Yes.

**MR FORNARINO:** There's not many, if any, psychiatrists who would do such a thing nowadays I don't think, or feel comfortable with giving a 14 year old a diagnosis of BPD. I was, and it turned out to be correct, but for me a diagnosis was a bit eye-opening and shocking. On one hand I felt relaxed and comfortable that I knew that there was something wrong, that it wasn't all in my head, it wasn't made up, but at the same time you'd have all these opposing views from mental health professionals who thought it was a load of rubbish.

**PROF KING:** Yes.

**MR FORNARINO:** They thought it was a wastebasket diagnosis and wouldn't treat you, and would make you feel excluded. It was just stigma - it's stigma all the time. So a diagnosis, while helpful in assisting my understanding of what I was going through, I can see to a degree how it wouldn't - may not be for some, because it's like "Well I've got a diagnosis. Now what? What do I do? Treatment is like two to four years away." That can be really confronting for some people, and I guess it all - it's all very subjective how a person feels on that type of diagnosis. I mean, some people get diagnosed with PTSD, which is very similar. Some people get diagnosed with bipolar, maybe wrongly or rightly. My concern is a heavy overreliance of medication.

**PROF KING:** Yes.

**MR FORNARINO:** And just medication, while it can assist in short-term issues with BPD, it does nothing long-term. That's what I've found for me anyway. I'm aware of a few - or at least one new drug trial by a company called Orison, I think, which has shown promising results for BPD. They've tested that on Alzheimer's I think. It targets an aggressive component of BPD and it's been very promising, so I look forward to reading that in future.

**PROF KING:** Do you have any questions?

**MS ABRAMSON:** I have one question, and also can I thank you for appearing today, because the lived experience really matters to the Commission, so that you've had the

courage to do that, thank you. What would have made a difference to you in school? Because one of the - you'll know we've got a very heavy emphasis in the report about providing support services for children and youth when they're in the school system by connecting outside.

So, I was interested when you said – and congratulations for going back to do law because I tell you, things like property law are boring at the best of times. So, well done, you. But what would have made a difference to you, do you think, or would nothing in the school system have been helpful?

**MR FORNARINO:** The problem with me is it wasn't just school; it was a variety of issues.

**MS ABRAMSON:** Yes.

**MR FORNARINO:** But school in particular, bullying was a huge issue. That's why I'm very interested in bullying and the effects and mechanisms schools use to deal with bullying. That affected me a lot. I'm not sure that there was much that could have been done. I mean I started showing signs when I was probably 10, 11, of just depression and isolation and wanting to be alone. I don't attribute that to the school system solely but it certainly didn't help. As I was saying earlier, this mentality of – well, students have a set curriculum. You've got to learn it or you lose it. That's a really bad problem and it's never revisited if something happens in a child's life. They've sort of missed that opportunity to relearn. I mean I don't know what school is like now but when I was growing up it really was you either learn it or you don't, and if you don't, that's, "Too bad. We're sorry".

**MS ABRAMSON:** We're very concerned. I mean congratulations to you, to be honest, getting back and getting to university because we're very concerned about students who fall out of the system all together. We're concerned about them inside but their prospects are so much worse in terms of employment and other things. So, we're open to any sort of creative suggestions on that front.

**MR FORNARINO:** Well, that was like with employment. I think I wrote about in my submission. I mentioned a New South Wales case.

**MS ABRAMSON:** Yes.

**MR FORNARINO:** (Indistinct words), where people need to be encouraged to apply for a job. They see a question like, "Do you have any medical disability that may affect your capacity".

**MS ABRAMSON:** Yes.

**MR FORNARINO:** I think that's really important to raise awareness in the mental health area that, yes, you can have a mental health issue. You need to assess whether you

feel like it's going to affect your job or not. By ticking "no" you don't on the box is not necessarily dishonest. If something hasn't affected you, then you should really apply for work. That stops a lot of people from what I've heard and from whom I've talked to. They're terrified of applying for work because they see a question like that and they'll flat out refuse.

**MS ABRAMSON:** Yet the strange thing is, and it's not perfect by any means, with a physical disability the employer is inclined to ask, "Well, what practical things do I need to do to accommodate your disability". I know that's not universal.

**MR FORNARINO:** No.

**MS ABRAMSON:** Mental health is just treated very differently.

**MR FORNARINO:** It is.

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

**MR FORNARINO:** Thank you very much.

**PROF KING:** Next, Morton Rawlin, and if you're able to state your name, any organisation you represent for the transcript and any opening comments like you'd like to make.

**DR RAWLIN:** Thank you very much. My name is Morton Rawlin. I'm a GP. I practise in Melbourne but I also have been a rural GP in the past. I am the chair of the General Practice Mental Health Standards Collaboration, which is an organisation funded by the federal government to look at the standards of the training of GPs to access the Better Access Medicare rebates.

**PROF KING:** Yes.

**DR RAWLIN:** The committee is in many ways unique in that it has representatives from the two general practice colleges, the psychologists, psychiatrists and, more importantly, consumers and carers who have active input into the standards. As an organisation, we have trained approximately 90 per cent of vocationally registered GPs and particularly fair access around high prevalence disorders which, in other words, is depression and anxiety. We would love to do some work in the lesser prevalent disorders, such as BPD, but that's not within our remit at this point in time.

I also have served on the College of GPs College National Council in the past, but the other thing that I do is I'm the Medical Director of the Royal Flying Doctor Service in Victoria. So, I'm connected in from that perspective as well.

**MS ABRAMSON:** You're very busy.

**DR RAWLIN:** Yes. Thank you. We have provided a submission.

**MS ABRAMSON:** Yes.

**DR RAWLIN:** I take that as standing. I guess the main things that I wanted to highlight were just some, for want of a better term, anomalies in the Medicare systems which tends to cause some issues for general practice. There are a significant number of GPs who are additionally trained in mental health over and above the level 1 mental health training who have additional skills, who do like to do mental health, who are interested and do like to engage with their patients. The difficulty for them is that if they actually treat people under the Medicare GP mental health items, that reduces the amount of access that those patients can get from psychologists.

**PROF KING:** So, cancer is one of the 10?

**DR RAWLIN:** That's correct. My particular interests are in CBT and I also do medical hypnosis. If I then bill the item number as an FDS provider and I also am working with a psychologist for the same person, we jointly have 10 items that we can do, but it may be better for us to have more, so that is an anomaly. What normally happens is I bill under a time-based normal consultation which means it doesn't show up as a mental health provider which falsely reduces the perception that GPs actually do treat mental health because we do.

I think that's one thing that if those two areas were uncoupled, that a GP with a particular interest and standing, and we do have the ability through the GPMHSC to regulate that and the training needs for that. If those two were uncoupled, patients would ultimately benefit because they're going to get good service from their GP, as well as from their psychologist. But also, as a bigger picture in the system, you'd actually be able to identify where some of that money is actually going.

**PROF KING:** Yes.

**DR RAWLIN:** At the moment it's just in the main pool.

I guess the other issue that has come up in the reports to date is the usefulness of the mental health treatment plans. I guess my comment to the Commission about that is that the perception of what a mental health treatment plan is for needs to be really clarified. The mental health treatment plan is really a guided way to guide the GP through the diagnostic process in the mental health setting. It's actually not the referral. I mean I do a lot of mental health plans but not all of them go to psychologists, not all of them go to psychiatrists, also, I don't always bill them. But it's an issue that it's a way to help the diagnostic process, making sure the doctors are aware.

One of the problems, and this is the same across Australia in many other specialties, is that in general practice we are a broad church. We have different ways of being trained. There is a large number of GPs who are trained overseas who have different views,

different training around mental health. I think the Australian graduates get definitely a better approach taught to them. I do try very much – I’ve been involved in GP training for a long time – to try and teach that as part of the process. Certainly, our registrars get training but not every GP has had training in terms of being registrar, as the international medical graduates are.

**PROF KING:** Can I follow up on just the mental health treatment plans?

**DR RAWLIN:** Yes.

**PROF KING:** Because in theory, as you said, it’s a broad church, so in theory they should be more than a referral and a part of the diagnostic tool.

**DR RAWLIN:** Yes.

**PROF KING:** But we have seen examples of mental health treatment plans. The one that sticks in my mind was one that just had the one word on it which was “depressed” and that was the entire treatment plan.

**DR RAWLIN:** Sure, yes.

**PROF KING:** Is there a way, and we obviously ask for more feedback because for a non-trivial number, I would say a significant number of GPs, they don’t have the strong interest in the area.

**DR RAWLIN:** No.

**PROF KING:** It is just a box ticking exercise that they go through, if I can call it that, to be able to get a referral on to the next stage of treatment. But then there are also GPs who do an excellent job with the mental health treatment plans and it differs. I wonder though, given that spectrum, is it better from a GPs perspective – let me give you an example. If I have a broken leg or an injured body, I go into a GP. The GP says, “Well, I’m not sure. Go and get an x-ray”. So, I go off, x-ray is back, now I see the doctor and the treatment goes ahead. Would that be a better approach for mental health in general, given the broad church of GPs, so that in a sense there’s the GP who would say, “There’s something going on here. I think it’s a mental health issue”, rather than the GP themselves trying to in a sense do a mental health treatment plan which is diagnostic or CLISI diagnostic.

There is a triaging service or there is another group of professionals, and the one that I’m thinking of is in WA, with the PORTS service that they have over there. Given the distances in WA it makes a lot of sense, the GP says to the individual - in a sense, refers them to PORTS. PORTS make contact with them within 24 hours, often through a phone contact, and then there is a more formal triaging to work out what direction we need to send you in next.

**DR RAWLIN:** There are a couple of parts to that question.

**PROF KING:** Sorry, it's a long question. I didn't mean it to be so long.

**DR RAWLIN:** No, no. I think it's a very relevant question. There are a couple of issues; one is around the GP's knowledge of the support services in their local area.

**PROF KING:** Yes.

**DR RAWLIN:** Some GPs may not be aware of all of the appropriate services, particularly for very specialised areas of mental health. So, that's one place where a diagnostic or a referral in the middle type process may help.

**PROF KING:** Yes.

**DR RAWLIN:** Now, theoretically, the primary health networks are supposed to be in that spot. Currently, I have to say that many are not, some are but many are not.

**PROF KING:** Yes.

**DR RAWLIN:** I think that from the general practice perspective, the critical thing is to make a decision about whether this person requires some support, and the mental health treatment plan helps the doctor to do that. Now, one of the problems and I can be accused of that from time to time, is that our notes perhaps are not as good as they should be. However, our referrals in terms of writing the referral should in fact be a lot better.

One of the problems I guess in mental health is that a lot of the mental health information is quite complex and to actually put it into a document in a 15 or 20-minute consultation, is actually really hard. Many of my referrals are quite brief; however, I actually ring the psychologists that I work with and have a 10-minute conversation with them about the background, what I found, what I'm doing with the patient and what I think they would benefit from.

**PROF KING:** Although I would suggest that that is not common practice.

**DR RAWLIN:** No, and I agree with that but I think the issue there is that there are ways to do it but the mental health treatment plan tends to focus the doctor a little bit in that it's not like a normal consultation or it shouldn't be.

**PROF KING:** Yes.

**DR RAWLIN:** I think there is a lot of work that we can do around making the process better, but I think having a DSM diagnosis in many ways can be counterproductive in a whole raft of things because mental health changes. We all have times when we are not good. We all have times when we're pretty good. When I'm bad I could be perhaps labelled as depressed, when I'm good, I wouldn't be. But the issues are if you do put a label on somebody, it is a label and it does come with consequences.

I certainly have patients who are very clear when we talk about these things that they do not want things on paper for various reasons. I am more than comfortable that that does not occur. I have had certainly personally patients who have been denied access to insurance, their superannuation and things like that have been affected. Their travel has been affected and their job opportunities.

There is a whole raft of reasons why a treatment plan may just have “depressed”. I would hope that there is a lot more on it but the diagnosis of depression is quite a broad one. There are people who are just a little bit melancholic, there are people who are severely and suicidally depressed and the treatment for both is very different.

The other bit that I would say is another issue for general practice, and following on from suicide prevention, is that a lot of the newer abilities for support for people with suicidality and suicidal ideation are actually quite good in that they are getting personalised support and all of those sorts of things. The problem for us in general practice is that in order for our patients to get access to that, we have to send them to the emergency department.

That is one of the worst places to send somebody with suicidal ideation. Even if you actually ring the emergency department and say, “Look, this is what’s happening. They need this, this and this”. I’ve rung the team. They are going to send somebody. If the team isn’t there waiting for them at the front desk, it is a nightmare.

**PROF KING:** Sorry, I just want to understand exactly what drives that. Is that for legal reasons if someone presents to a GP and says - - -

**DR RAWLIN:** No, the services are not able to be accessed through general practice. It’s as simple as that.

**PROF KING:** Okay, yes.

**MS ABRAMSON:** I’m just mindful of the time.

**PROF KING:** All right. My apologies. I’m mindful of the time. Thank you very much.

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

**DR RAWLIN:** No worries.

**PROF KING:** Ms Leanne Longfellow.

**DR LONGFELLOW:** That’s me. Hello.

**PROF KING:** Hello, if you’d be able to state your name and if you’re representing an organisation, which organisation and any opening comments that you’d like to make.



**DR LONGFELLOW:** My name is Leanne Longfellow. I'm not representing any organisation. I read the report through the lens of family experience and that's what I'd like to share today. I work in the area of disability, with children with disabilities and I have a PhD in that area. This is about it really destroying my brother who had schizophrenia and other disabilities and moved interstate. Just to paint a picture of him, he was diagnosed with schizophrenia when he was a teenager and in and out of hospital and really couldn't care for himself. He was on a disability support pension and lived in Housing Commission. He needed help with basic skills.

I thought everything was fine up until last year. So, I had been unable to make contact with him. He didn't use the internet. He only used the phone and had been unable to make contact with him by phone, and I was a bit concerned about this. At the time, my own daughter was in intensive care so I did put it on hold for a while. On the day that she got out of hospital, I rang the police and also my brother had, and I must be really clear about this, I thought he had a whole lot of support. He had different organisations because he couldn't look after himself. He was an NDIS recipient or I thought he was; he certainly had been. He had all these different organisations and it involved in home care.

When I wasn't able to make contact with him, I thought everything would be okay because someone would ring because there are people going in to the house. So, I rang the police, and this is interstate. That night at 10 o'clock, two police knocked on my door and told me my brother was dead and had been dead for two months. I can't convey how distressing that is and for me to try and understand as the only family member left, to understand how when you think someone is really well supported and they're not and all his services had been cut off. We're talking about someone who couldn't make a meal and had other disabilities.

Since that day, what I have done is I have contacted every organisation, obtained a verbal account from each one and, where possible, a written account. I've obtained his medical reports. I've spoken with the NDIS, obtained police statements. I have become executor of my brother's estate so that I can do all this. I have obtained information from the coroner. They were unable to do an autopsy because of the state of his body, so I will never know how he died.

What is startling is that policy was followed. Policy was followed and we've got someone dead on the floor for two months. I just don't understand. I want an inquest. At this stage, it's not clear whether there will be an inquest into his death but what I can see from my reading of my brother's notes, I believe there were three key problems.

Firstly, the interaction between mental health services and the NDIS because both of those were cut off. Mental health services claim that it had nothing to do with my brother becoming an NDIS recipient, but I don't understand how someone who at 35 years had nurses in his home and social workers can suddenly decide, "Well, you're doing okay". This is someone who occasionally live in his back yard when he was in psychosis. He

couldn't look after himself. Why would that happen? His NDIS was cut off because he didn't go to a meeting, so that was cut off.

For 35 years he had care from a hospital and he had case management, but with the NDIS there was this really fragmented service delivery and he didn't have case management. I thought he had case management; he had a support coordinator. They do not do case management. But someone like my brother, who can't look after himself, needs case management.

When I was reading the report, what really bothered me is this notion of economic participation and enhancing productivity and economic growth. They're the words used in the paper. There are some people in our society who are never going to work and they still should be valued. They still should be valued.

**MS ABRAMSON:** I don't think there's any disagreement from the Commission on that.

**DR LONGFELLOW:** I certainly think in our society – the premise of the NDIS is based on people contributing and I did feel that a bit in the report, that that was the case and that we need our society based on it and valued on it.

Certainly, after my brother's death, when I was trying to advocate for him, I felt that there was a lot of stigma around disability. The way I was treated, I was treated with enormous disrespect by some organisations. I will say the NDIS were very helpful, they were very helpful. Others were not. An example is the police asked me to – I flew over to organise a funeral for my brother, once his body was released from the coroner.

The police mentioned that they wanted a statement from me and, as his only relative, you would think that would be an important thing, and the only person who had contact with him. When I arrived at the police station, they told me to get in a line and I waited for hours, alongside people who had lost their mobile phones. When they finally spoke with me, they said, "We're too busy to take a statement". I'd flown from interstate. This was on a Friday and they said, "Come back on Monday". The same thing happened on Monday. They never got a statement from me until I made a complaint with the police.

It just wasn't considered an issue by a lot of people that someone is dead in the house for two months. It just – I mean (indistinct words) and distressed me but it just wasn't. I know the death rate of people through the NDIS or statistics that were released for a three-month period are a very high number and not all were due to the NDIS and some are natural causes. But my brother is one of those people and even though it's not deemed as being related to service provision, it needs to be looked at, it really, really does.

People like my brother need case management. When I've gone through this fragmented service delivery, all these different organisations that were involved, but none of them spoke with the others. None of them really knew how to support him. Actually, they all

told me that the NDIS plan was about getting him work. He would never go to work. He had numerous disabilities. He couldn't look after himself.

**MS ABRAMSON:** Did he have any community nurse attending him because a lot of the people in this cohort do have someone that comes regularly to check on their medications, et cetera?

**DR LONGFELLOW:** He did have that. He was under a hospital. He was under Concord Hospital in Sydney.

**MS ABRAMSON:** Yes.

**DR LONGFELLOW:** Then they thought that he was doing very well. He was discharged to a rehabilitation centre and they said that he was doing well. I obtained all the notes. They said that he was doing so well he was discharged, but on that form, it's all incorrect. They said that he'd never tried to commit suicide. He would regularly try to commit suicide. They said that he wasn't isolated. My brother was so isolated. I was the only person who spoke with him. He had one friend in the whole world, so I would fly over once a year with my brother. I spent time with him in December 2018 and saw him face to face. I spent over times over time.

In December 2018 I said to him, "How is your friend, Brian" and he said, "I haven't seen him". After my brother's death, I found out that Brian had been dead for two years. We're talking about someone incredibly isolated who couldn't look after himself and had no connection, and the box was ticked that he wasn't isolated.

**MS ABRAMSON:** How could we improve that process because one of the concerns that we've certainly had raised with us is that loved ones, when someone is admitted to hospital, the hospital often says for confidentiality reasons they won't share the treatment plans or the notes. Yet when you actually ask people who worked in the sector, they say that having the conversation in the right way with the patient, you very often will get that consent. So, would something like that have made a difference to you if you had been able to be involved like that?

**DR LONGFELLOW:** Yes, I think one of the other things is the complexity of it all because – I'm just not sure. I thought – I talked with my brother about him having support coordination and I thought that's a great thing.

**MS ABRAMSON:** Yes.

**DR LONGFELLOW:** But it wasn't until after his death that I found it wasn't what I thought it was.

**MS ABRAMSON:** It wasn't a personal interaction, it's a back-office thing of putting things together. But you assumed, I guess, and you correct me if I'm wrong, that someone was actually going in and knocking on the door or ringing him.

**DR LONGFELLOW:** Yes, yes. I thought he had human support.

**MS ABRAMSON:** Yes, because he had pre-NDIS?

**DR LONGFELLOW:** He had it previously and it was all removed. I just don't understand. I mean to me is that economic restriction. Why do they do that? It must be. I certainly hope there's an inquest into my brother's death. I think we can learn a lot from this because I've also been told my brother is not the only person this has happened to. It's unacceptable; it's just unacceptable.

**MS ABRAMSON:** We have not particularly looked at NDIS because it was outside what we're going to look at, but your evidence today is a very important reminder for us and thank you for sharing it with us. Sorry for your loss. It means that we have to think very carefully about what our care coordinators would look like. It's not just a back-office function. We'll have to think about how can we be sure that people are actually interacting as they need to be.

**PROF KING:** Yes, and also linking up the information.

**MS ABRAMSON:** That's right.

**PROF KING:** The idea that the rehabilitation centre could have just have what are effectively the wrong medical records is frightening and it should not occur. We should have a system that links up the information, otherwise people will make the wrong decisions and we know there's fatal consequences.

**MS ABRAMSON:** True, but one of the difficulties would be that with your brother's information it's the cross checking and if someone has an acute disorder, then they're not on their game to say, "Well hang on a minute, is that right", so that's the other issue.

**PROF KING:** Yes. Things like attempted suicide, it should be recorded somewhere.

**MS ABRAMSON:** It should be recorded somewhere in the system, yes.

**PROF KING:** It should be recorded somewhere. It shouldn't necessarily be an individual's – "Well, have you attempted suicide?" "No."

**MS ABRAMSON:** No, no, I understand. Was there anything else that you wanted to talk to us about?

**DR LONGFELLOW:** Just the last point is to really drive home that NDIS don't provide mental health services because I think when I was speaking with different people from the rehabilitation centre and the hospital, they all said to me, "Your brother was receiving NDIS". I said, "Well, was that the reason why his mental health services did not

continue”, and they said, “No”. But why mention that and why was he discharged? It doesn’t add up.

**MS ABRAMSON:** No. Well, one system didn’t see what the other system was doing for him. No, I understand.

**DR LONGFELLOW:** Yes. So, to me there’s lots of gaps and I think that interface between mental health and NDIS and how to handle care management. For the people at the pointy end to mention NDIS, like people can’t look after themselves. I have a lot of guilt because my brother was interstate. I thought about bringing him out to South Australia but I actually thought he had good service provision where he was. For me it’s gut wrenching that I wasn’t aware that he wasn’t receiving good service provision.

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

**MS ABRAMSON:** Thank you for being courageous enough. It’s no comfort probably but we’ve listened very carefully to what you’ve said to us, so those are some of the things we will think about in terms of our work, so thank you.

**DR LONGFELLOW:** Thank you.

**PROF KING:** Thank you very much. Next, Sally Tregenza, and if you can just state your name, any organisation you represent, and any opening comments that you have.

**DR TREGENZA:** Okay, thanks. My name is Dr Sally Tregenza. I’m a psychiatrist working in the public mental health system in South Australia and I’m here representing the Royal Australian and New Zealand College of Psychiatrists and, in particular, the South Australian branch of the college. The branch works as a committee sort of responding to mental health issues that are relevant in South Australia.

I guess we see the college’s role as advocacy in the mental health space, representing the view of psychiatrists. Often, we do get feedback directly to our branch from other psychiatrists or the general public or GPs around difficulties with accessing mental health services and problems in the system.

The college has formally responded to the Productivity Commission with quite an extensive response, but I thought today was an opportunity to talk about a few points but particularly South Australia. Would you like me to just sort of start?

**PROF KING:** Yes.

**MS ABRAMSON:** Yes, we’re looking intently at you.

**DR TREGENZA:** Okay. I think also just to kind of comment that we would obviously be able to make comments on probably most things in the report, so I tried to choose some of the most pertinent points. I guess our main issue was about supporting people at

increased risk and a few things have come up over the last few years, particularly around the need for increased services for people with developmental difficulties.

These are people who have an existing intellectual disability and probably are cared for by services such as NDIS but often people do present with mental health difficulties as well. They are exactly the sort of case referred to where there's the sort of gaps in the system between the disability sector, which is sort of NDIS supported, and the public mental health service.

At present there's only one half-time psychiatrist who treats children and adolescents with these conditions sort of funded through the Women's and Children's. The adult position has funding but this has actually been vacant and the service has been unable to find a psychiatrist to sit in that role. I guess we continually advocate around these issues and we have meetings with the Minister for Health and Wellbeing twice a year. That's not on the agenda but we are very concerned about this particular group of people.

Another area we think there are quite significant shortfalls in the system is around forensic mental health and that's in a couple of areas. If prisoners have mental health difficulties and those aren't at the level that they're actually cared for by the mental health service such as James Nash House, then at present there isn't actually an in-reach service to the prison. So those prisoners are managed by the GP, and they can get support by contacting the forensic mental health services, but there isn't funding to actually support an in-reach clinic where a forensic psychiatrist and mental health workers, that specialist interest - - -

**MS ABRAMSON:** Could I - - -

**DR TREGENZA:** - - - provide a service.

**MS ABRAMSON:** - - - just ask you about that if you don't mind me interrupting. Different states have different models for forensic care. So is it that the Department of Corrections theoretically is supposed to be responsible for that person's care in prison?

**DR TREGENZA:** I believe that's the case, yes.

**MS ABRAMSON:** I am not saying it is delivered, just the model.

**DR TREGENZA:** No. And I also think that kind of highlights again the problem of different departments providing care, because mental health care is the health and wellbeing and funding comes from Corrections.

**MS ABRAMSON:** Corrections. Yes.

**DR TREGENZA:** So there has been a budget where this has been allocated more funding, but that hasn't actually kind of come to fruition at this time. We do have specialised services for young people under 18 in correction facilities, and in that

particular service there is a visiting psychiatrist and a mental health team that supports these young people.

The other area is around after prisoners are discharged or even people who have been in services such as James Nash House, which is a prison hospital, there needs to be more support, further community mental health teams to have some specialised forensic input, because the forensic psychiatrists work under forensic mental health in a sort of siloed area.

**MS ABRAMSON:** Yes.

**DR TREGENZA:** But a number of people who have perhaps committed quite serious crimes in relation to their mental illness are then eventually referred just to the community mental health team for follow up, and there is feedback that some of the psychiatrists and mental health workers don't feel that they are specialised enough in those particular forensic issues.

Perinatal mental health was another area that I think was worth mentioning as there's a strong push for the government having universal screening around perinatal mental illness and awareness that pregnancy around the time of delivery are risk times for women's mental health, and obviously the impact this has on the developing of the infant. The problem at the moment is the recommendation seems to be (indistinct) around increasing screening provision, but of course once people are screened there's going to be increased numbers of people who have concerns, and there's no - as far as we could see there's no actual funding allocated to increase the services provided through perinatal mental health.

So we think there is a shortfall in psychiatrists that work in this area, and the psychiatrists that do work in the area are under a lot of demand; not just psychiatrists but the mental health teams. So we would like to I guess see the Commission go further to make a recommendation about actually more service provision, not just screening.

Just briefly I just wanted to touch on substitute disorders as well, because again that's a very significant gap in the service between who provides support for people with substitute disorders who also have co-existing mental health difficulties. We know that people with mental illness often use substances either as a way of I guess self-medicating the illness, or it's an opportunity to feel somewhat better or more alive, and often these people do fit that fall between the gap between the substance use type service perhaps thinking the mental health difficulties are too severe to be able to fully support that person, and the public mental health system often will say they can't be of assistance because of the substance use difficulties, and I think that's been highlighted probably I am sure by other people.

Just a comment around improving emergency mental health experience. As you would probably know it has been a major issue in South Australia around issues such as ramping and wait times for patients, particularly psychiatric patients, and we think this needs a major overhaul. I think there needs to be consideration to actual thinking about the

physical environment in emergency departments, because we know they are incredibly busy, noisy and intense spaces, and I think an idea around creating specific spaces for mental health patients would be very helpful.

**MS ABRAMSON:** And we have got something in our - we've got a recommendation around that.

**DR TREGENZA:** Yes. Just we also do get feedback from our members. So psychiatrists that go to do reviews in the emergency department say of course that that environment actually worsens the condition that the person presents with, and I think also already there's some good ideas that have been proposed by the South Australian Government in the mental health services plan around creating alternatives to coming to the emergency department, such as urgent mental health care centres and a safe - - -

**MS ABRAMSON:** We have got something, I am sure you're familiar with it, St Vincent's Hospital in Melbourne which is a really - they've got like a café that's associated and other services so people don't have to go into emergency.

**DR TREGENZA:** Which are great ideas, and I think it's concerning that that hasn't happened here for many, many years. There used to be a service through public mental health that was a specific team called the AACIs team, it was assessment and crisis intervention, and that was also emergency avoidance in that people could refer an someone could go out and do an urgent home visit. That service got absorbed by general mental health and hasn't really been replaced.

**MS ABRAMSON:** This is one of the depressing things if I may say so about our inquiry. There are often these really good initiatives. So many witnesses have come to us and said, you know, that worked really well but it's been defunded.

**DR TREGENZA:** I know, and I do - I think particularly when Leanne was speaking, I mean one of the thoughts that came to my mind is that I think everyone's aware mental health services need increased funding, because I think people who work in them also know they are stretched to capacity, and I think that's why some of those difficult decisions are made.

**PROF KING:** Can I - I was going to wait until further - there's two elements there. So a number of areas you've said there's a shortfall of services, so child and adolescent, perinatal psychiatric, and so one issue there is obviously funding, but the other issue is the actual people, clinicians on the ground, and we could double fund psychiatric services tomorrow, but that's not going to create one more psychiatrist.

**MS ABRAMSON:** Not for seven years or longer.

**PROF KING:** It's not clear it would create any more psychiatrists, because my understanding is unlike some other medical specialisations where there is more people trying to get in to the specialisation my understanding is psychiatry is perhaps not one of



the ones that people are knocking down the door to get into. So it's not even - my understanding is it's not necessarily a matter of we just need more places in psychiatry. So correct me if I'm wrong, because you're looking at my quizzically. So how do we increase the number of psychiatrists?

**DR TREGENZA:** Yes, I think that's a really good point, and in fact we had some notes on - I mean I used to be a director of training for child and adolescent psychiatry, and in that area in particular there's only three to four funded spots sort of over a two year period. So we really are not training sufficient numbers of child and adolescent psychiatrists, and we also train in perinatal mental health as well. I think there are more applicants than positions. So for South Australian psychiatry training there's always a greater number of people who apply and our numbers are limited by the availability of funded training positions, and there's a couple of areas that are major shortfalls. So child and adolescent; the budget at the Women's and Children's hasn't been increased at all for psychiatry numbers or training positions, despite advocacy by my own department as well as by the college, and consultation liaison psychiatry which is psychiatrists seeing people who are part of the general hospital system, so perhaps admitted with a medical problem, but they've got whole existing psychiatric illness, or they are presenting after an overdose. So both those areas only have limited training registrar positions, and that actually caps our numbers of people who are able to apply.

So I think in South Australia there would be a great push to say we do need more trained and training positions, but they do need to be funded, and part of the problem is that they do need to be funded by the public mental health system to enable the training experience that's necessary.

**MS ABRAMSON:** Well, it's interesting because we do - I am sure we have got some, a commentary around that, around the need for more funded places for the trainees, because that's certainly - the public system. But the other thing I think - I don't know that we made a recommendation - was around the role of the private system, whether it could also be able to provide - perhaps not in some of the areas, but in other areas whether they could have places.

**DR TREGENZA:** We've actually had a project in South Australia in the last few years where we explored that, and funding was given through the training committee to sort of try and progress training for the private sector, and in the end it was disbanded, which has also happened previously maybe 20, 30 years ago, and it just seems to be a very difficult space to provide training opportunities, because patients are referred to see a particular psychiatrist. Most of the time GPs who have done the referral and patients who are waiting to be seen do want to be seen by the psychiatrist and aren't so happy to be seen by the trainee.

**MS ABRAMSON:** And I guess in the private system perhaps even more so because they're making the choice to go to that, they're not at emergency at the hospital - - -

**DR TREGENZA:** Well, exactly, and it's not really an issue in the public system in that we know all training psychiatrists are supervised, and the same - - -

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

**DR TREGENZA:** But it's been incredibly difficult. It's also a bit difficult around practical issues such as, you know, medico-legal sort of insurance to cover - - -

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

**DR TREGENZA:** So it hasn't been a successful year, but I believe there's been training positions interstate that have been able to offer that.

**MS ABRAMSON:** If you don't mind taking that on notice and just dropping us an email about that, that would be really helpful.

**DR TREGENZA:** We absolutely will follow up, yes.

**MS ABRAMSON:** Thank you.

**DR TREGENZA:** I don't want to take too long, I just if I can just make a comment around the consultations by video conference, because we've had quite a lot of feedback about the proposal for reducing the funding for MBS item 288, which is for a telehealth consultation there's additional funding to support the fact it's occurred. I think the general feeling is that if this was to occur I think there will be a disruption of services. So a lot of psychiatrists who do telemedicine or tele-psychiatry consults bulk bill those services because they are getting the extra funding, and often it's easier than trying to chase bills from people who are rural and remote and a long way away, and I think if people no longer are able to bulk bill they will stop that working service. So I think that financial amenity did benefit the patient, but also I guess make the process easier for the doctor. Am I running out of time?

Just one issue that's been another problem specifically in South Australia is the provision of 291s which are one of psychiatric consultations where the psychiatrist provides an assessment and management plan to the GP. There was a service through private health network that helped organise this, and so they took the referrals and then found the psychiatrist. We understand that's been disbanded earlier this year, and I'm not sure, I haven't had the information yet about that. However it didn't work very well, because a lot of the time people would be referred and then when the psychiatrist had (indistinct) often there was a (indistinct). This did prove quite difficult, so just to make that comment. That model hasn't worked very well in South Australia.

**MS ABRAMSON:** Is that covered in your submission?

**DR TREGENZA:** I think so, yes. Just briefly we've got a particular shortage with areas such as people willing to treat adult ADHD, specifically in our state, and I mean one thing

if tele-psychiatry could provide those numbers like the 291 or there was an incentive for people seeing patients with these disorders I think - I mean the interstate service may be able to actually sort of help fill those gaps. Having said that there's often gaps that people are required to pay as well as the MBS funded proportion. So I still think there needs to be consideration of the public mental health service providing treatment for that particular disorder.

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

**DR TREGENZA:** That's okay.

**MS ABRAMSON:** No, that was fantastic. Thanks. Now, we have to take one person before the other one.

**PROF KING:** I think next Pat Sutton.

**MS ABRAMSON:** Yes.

**MS SUTTON:** I just need to pour my water first, I'm extremely nervous, especially after hearing Leanne's presentation, because she makes - strikes it home to me how important it is that carers - - -

**PROF KING:** Sorry, just before you start there, Pat, if you're able to state your name, if you're representing an organisation what it is.

**MS ABRAMSON:** That's because we know Pat already, so she's comfortable.

**MS SUTTON:** I was privileged to be here yesterday too.

**PROF KING:** But it needs to be on the transcript.

**MS SUTTON:** Sorry. Pat Sutton - I'm actually retired. I still do lots of advocacy work in the mental health sector, but I'm speaking on behalf of people with - very specifically people with severe mental illness. They are often referred to as those without a voice. I prefer to call them the preferably unheard, or even deliberately silenced, and that's how I see it. I have two sons who have never been asked their opinion in 28 years, and I know many others in the same situation, and there's lots of reasons, fear of retribution, fear of discrimination, et cetera.

There is so much spoken about consultations, and I believe that there's an awful lot of tokenism involved in this, especially in South Australia, in my view. One example is a few years ago the consumers and carers in the western region put together a petition of several hundred consumers and carers fighting against the closure of two intermediate care centres that was planned for (indistinct) in South Australia and it was a step up step down. Two of them, we've only got two of them now, and of course there's no way you

can use them as a step up, they're only step down now and very restricted populations use them.

I have been a carer and a consumer advocate for 29 years, and I've been working as a carer consultant in the mental health system since 1999 when I gave up my job in admin and decided to work in the sector. I've worked at local, state and national level, including non-consumer and carer advisory groups, and so I've kept wide networks, I maintain wide networks of consumers and carers across Australia, so I don't only speak from my own lived experience, I do bring other experiences too. I also had 12 years on the Guardianship Board as a community member, and this restricted practice is one of my priorities, and (indistinct) about people services.

I have heard many ministers bemoan mental health as the bottomless pit of funding. My belief is that because funding goes - and we did discuss this yesterday a little bit - funding goes into the hospitals. I absolutely believe that this cohort of the population, we need to move away from crisis driven hospital-based services and increase community services so that people can be kept well at home and in the community. There needs to be incentives for community services to keep people well, rather than the current incentives that are given to hospitals, and to avoid those lengthy queues in emergency departments which have been referred to.

Suicide prevention in my view only focuses on people with anxiety and depression, most of the anti-stigma campaigns, who do require therapy and talking, whereas a large proportion of people with schizophrenia for instance, and we're talking 10 to 15 per cent of people with schizophrenia, don't require the talk and therapy. What they require is the three things that are seen as the basics in life that everyone wants and needs; a home, a job and a friend, and many of them do not have that. What they suffer from is not depression, it's something I am told by a psychiatrist is called existential despair.

I think it's absolutely vital that people who provide services and support to people with severe mental illness, particularly those with psychosocial disabilities have time to gain trust, to build a rapport and have empathy and a caring approach. The system needs to work towards employing more of people with those characteristics in my view. The barriers which should be used to be driving services instead in my view are used as an excuse for substandard care and I think we heard that from Leanne. Lack of insight and ability to articulate goals, lack of confidence, lack of self-esteem all in the name of recovery apparently.

An oft repeated phrase that families hear is it is their choice. Perhaps they like to live in squalor, perhaps they like to eat unhealthy foods. Perhaps they like to be isolated in the community. It's not least restricted practice to avoid assertive services for some population, particularly when this leads, and it's been demonstrated that it leads to the person avoiding detention and hospital, and I saw that so much in my 12 years on the Guardianship Board. I do not believe people want to live in substandard residential facilities or with overburdened and aging family members, but of course at least they are

safe, and certainly in South Australia there's no - there's no alternative for many of those people.

The lack of supported accommodation, and again particularly in South Australia, is an absolutely unacceptable state of affairs in our country. Other countries, particularly in Nordic countries, have really good examples which work, and our cheaper than the revolving hospital doors - hospital syndrome, which is still maintained by many people.

My sons, Peter and Ben, depended on my husband and I for 28 years for all of their daily support. Peter spent many, many years in hospital. The first ten years of his illness one admission was actually two years in a closed ward, and that was only one of them. This is very expensive to the community. Now they live in a house which is divided into two flats, which the family purchased for them. They receive 14 hours shared support every day. So if the very successful core and cluster type housing, which people in South Australia seem to avoid, was utilised where we have six people living in separate flats my sons 14 hours can be divided into seven hours each. So if we had six flats you'd be divided into four hours each of funding. I mean if you can - I can't understand why people can't see that. There's an economic gain in that kind of housing for people who would benefit from it.

I have to say that the NDIS has transformed the lives of my two sons and also the rest of the family. However, this was due to very, very strong advocacy by my family. Many others are not receiving the support that my sons are, which is why I'm not really retired. They're not getting the help they need from the government or the non-government agencies to understand the new language of the NDIS; that is it's about impairment caused by the mental illness, it's not by the symptoms of the mental illness, and that's still being repeated by a lot of people.

The mental health non-government agencies are even struggling themselves with this I understand, and they have tended to resist the NDIS over the years, which I've been very frustrated with, but this is because their own organisations have been put at risk. In my view the mental health peak bodies do not represent consumers and carers, they represent their own organisations, rather than speaking on behalf of consumers and carers.

People with schizophrenia have significantly reduced lives, less than 50. My son is now 49 and this is a concern to me. This is due to physical health issues. They don't die because they have a mental illness, they die because they don't receive timely services and supports for the physical health issues they endure, and often caused by the antipsychotic medications that they take; diabetes, heart attack, cancer. Ninety per cent of people with schizophrenia smoke because they see it as an activity, because they're not engaged in new activities because they don't get enough support.

There is a significant lack of GPs, and to me is the significant contributor to long waiting queues in the emergency departments. This is particularly the case regarding GPs willing to take on people in this cohort of the population. My sons recently were cared for by a GP from an agency called Adelaide Disability Medical Services, but the Federal

Government defunded it. The GP used to come to my sons' home every six weeks or so and spend at least an hour, because my sons come and go, they won't just sit and listen to someone, but she succeeded in engaging with them where no one else had, and I believe she has certainly helped them to avoid hospital, especially one of them during that time.

One of my sons has got diabetes and an eating disorder and he's a vegan, which is almost as bad as the other two things, and the other son has chronic venous disease in both his legs. There needs to be a system other than the fee for service, which is what the Adelaide Disability Medical Services had, and I don't understand why it was defunded. It's so vital for people with disabilities.

Currently a new agency, a new non-government agency supports my sons. So after 28 years of waiting this started last April. The achievements they've made are incredible. They send photographs. I have one of my son's doing yoga, the other one goes fishing just about every day.

**MS ABRAMSON:** Not the vegan son presumably.

**MS SUTTON:** No. He won't even let them kill flies in his house. He made - the other day he made them suck ants out of his house with a vacuum cleaner and let them out outside. He has a strong respect for life in every form. They go for long beach walks. They have a lead worker. There's six workers all together manage those 14 shifts a week. He manages all the multiple medical appointments my sons have with specialists and psychiatrists, and he actually gets them to go to some appointments, which is something we struggled with for many, many years. These sound like basic things, but we've been without that support for 28 years. They were extremely isolated and dependent on us completely as I say, despite my strong advocacy in the sector.

The secret of these support workers is empathy, a caring attitude, spending time with my sons. Not academic qualifications, they actually - most of them don't have academic qualifications. Keith and I, my husband and I now have serious health issues ourselves. We're both now in our 70s and our support is absolutely unsustainable. So it's been quite timely in a way. So after 28 years of frustration, despair, grit, my motto has been don't get too excited. I know Leanne's story is not unique and I do believe that at least one of my sons would not have survived without our advocacy and support.

I think that what was needed in Leanne's case and in my sons case and most other people who have got severe mental illness is that coordinator we talked about so much now. Someone who's accountable for speaking to everybody involved, including the family, because family will often - and that's got to be assessed I understand too - might give a more realistic situation, because it's often quite different to what the person themselves may say. My sons will say they don't have a mental illness, they don't have diabetes, we don't need support, and yet they have accepted extremely well that 14 hours of support a day, but it's because of the attitude of the workers.

**PROF KING:** And the individual.

**MS SUTTON:** They don't go away. My sons know it's not going to go away. They know it's going to be there, and so they have to accept it, and so they learn to accept it. My son - one of my sons doesn't talk at all, he writes notes to them saying how much he appreciates their care, even though sometimes he tells them to 'f' off. I shouldn't finish on that line, should I. So I'm hopeful and I hope that a lot more people in my sons situation, and I know they're out there, become participants of the NDIS and also have a successful story as ours has been.

**PROF KING:** Thank you, Pat.

**MS ABRAMSON:** Thank you, and also thank you for assisting us yesterday.

**PROF KING:** Can I just - it's really a comment more than a question, but I think your comment about what is needed often isn't the qualification, it's the empathy.

**MS SUTTON:** Absolutely.

**PROF KING:** I'm not sure how they teach that.

**MS SUTTON:** I know that. I mean I've had to actually discontinue services of three agencies in the care of my sons over the last three years.

**PROF KING:** That time with the NDIS or - - -

**MS SUTTON:** No, the NDIS only started in April last year, but it was at that time when an agency which had been support to my son, with not so many hours of it, it was lesser hours, just seemed to not understand that we now have choice and control, this is what we need, but we had to fit into their policies of what they thought, just to make a long story short, and it was not suitable for my sons, and against my wishes, because I really respected this organisation, it's one of the larger ones, and I wanted them to continue, it just wasn't going to work. They wanted to do - they wanted to split the work for my sons into different workers. So you'd have all these different workers coming into their house, and they had restrictions on the kind of work they could do. They couldn't supervise my son's diabetes because it didn't fit with their policies and practices, despite the fact that they have agreed to do that previously.

So there were just things that just weren't going to work, and luckily I found this organisation which is newly developed, it's only been around for about two years. It is mostly people from India with Indian backgrounds, so I do think that they do have a very caring approach perhaps. I don't know whether it's because they're people from India, but they're all - all the six workers are just fantastic. For instance there was two of them, two women in the very beginning I could tell did not have a lot of confidence and they were a little bit worried about whether Peter would respond to them and whether they would be able to engage well, and now - in April they started and now they're fantastic, they're two of the best workers, and it's just because they persisted and they learned to pull away.

I think it's been useful because Peter and Ben live in - one lives in the flat upstairs and one down, and if Peter's telling them to go away and any particular time they'll go downstairs and talk to Benny. They say invariably when they see Peter again that he's fine again. So it's just learning, spending the time, and this is why it's so important for people to have time. I mean I do believe that Leanne's brother - there was no one who was spending time with him to work out what was really going on with him. I can't believe that there was, otherwise they would have learnt - maybe not what was going to happen, but certainly what was needed, and to say that a person that she's described that their goal is to find employment I find crazy. You know, one of my sons says that too, and he's got it in his goals, but first and foremost in his goals is that he needs the support to live independently in the community and to engage meaningfully in the community.

**MS ABRAMSON:** Thank you.

**PROF KING:** Thank you, Pat.

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

**MS SUTTON:** Thank you.

**PROF KING:** Next we have Danielle Malone. No, we don't, sorry. We are having lunch then, my apologies. That will teach me to look at my phone. Thank you, my apologies. We will break for lunch now. If we can break for - what are we looking at in terms of time. So if we can be back by 1 o'clock. Is that okay? Back at 1, an executive decision.

**LUNCHEON ADJOURNMENT**

**[12.23 pm]**

**RESUMED**

**[1.03 pm]**

**PROF KING:** All right. Okay, let's get started again. Next if we can invite Danielle Malone.

**MS ABRAMSON:** Can we apologise for us eating.

**PROF KING:** Apologies for us still eating. Danielle, if you're able to just state for the transcript your name, any organisation you represent.

**MS MALONE:** Sure. Okay, so thank you for the opportunity. My name is Danielle Malone and I'm presenting an individual submission today, not representing any affiliations mentioned herein. Thirty years of experience in public education as a teacher and ten years in educational wellbeing as a school counsellor and wellbeing leader for students aged between 5 and 18 years has provided an insight into opportunities this inquiry presents. Additional experience with chronically disengaged youth from 15 to 25



years of age with an MDO has equipped me to speak about transitions into adult life for young people with mental health barriers.

Firstly I would like to highly commend and concur with your reform objective of better use of childhood services to identify and enable early intervention for social and emotional developmental risks. Early intervention and prevention recommendation 17 of the draft report acknowledged many necessary actions. However, without accountability the measures will have minimal impact as they are effectively in place already, but resourced and utilised in (indistinct).

I strongly believe that the effective whole population mental health prevention and intervention will only occur through enforced wellbeing standards at preschool, primary and secondary levels of education. With standardised screening and compulsory intervention life outcomes and productivity for individuals and hence the wider community could expand exponentially.

Young people are highly susceptible to mental illness and that's the issue (indistinct) notes, many mental illnesses commence at school age. After listening to submissions from child psychiatrist Dr Goodfellow and Professor Paul I now understand that mental health conditions can also present in infancy. Children and families are legally obliged to interact with education facilities, public or private, and as such teachers have unique relationships with students that cannot be replicated.

As with many industries human resource accountability is key and time is poor. This is especially the case with early childhood educators, primary and secondary teachers, with student complexities presenting increasing difficulties. The enforcement of NAPLAN within schools has diminished the focus on wellbeing within the department and therefore in schools. South Australia has highly commendable systems, processes and personnel. All that is needed is the benchmarking to ensure social and emotional learning preventions and early intervention is undertaken as part of school compliance processes.

A plethora of evidence indicates the benefits to learning of improved wellbeing, yet this is not emphasised in education departments. Should there be an enforced standardisation of wellbeing reporting and intervention attention and resourcing (indistinct) does not equally into wellbeing.

Stigma is an issue that has underlined a great deal of intervention at individual and systemic levels, and is a question that has been asked repeatedly in the public hearings that I have viewed. The use of specialist services is minimised by parental and possibly workforce fear of stigma. Like the infant mental health referral disconnect that Professor Ball spoke of school age referrals are significant disconnect also. In the South Australian Department of Education annual reports on behavioural incidences the number of individuals exhibiting repeated behavioural incidences is considerably higher than those referred to the specialist support services. All support service referrals require parent consent, and many parents fear the stigma of a label disability, be it physical, cognitive, social or emotional.

In order to rid this stigma in early prevention and intervention I believe the hierarchical taxonomy of psychopathology (indistinct) model of risk identification and targeted intervention would prove highly (indistinct). This model uses trans diagnostic spectra beginning with the internalising or externalising as a first stage of general psychopathology, and fear or distress and substance use or antisocial as the next stages.

For (indistinct) taking a masters in global public health with preventative mental health being focused I have discovered research from a number of scholars using this model for early intervention. Forbes, Rappaport and Kruger present a stepped intervention using this model in their paper titled 'Opportunities for the prevention of mental disorders by reducing psychopathology in early childhood.' This was published in the Elsevier Behaviour Research and Therapy Journal 119, and I have a copy here for anybody that's interested, and there's also a digital copy on there.

**PROF KING:** Yes.

**MS MALONE:** In regards to recommendations in the paper I will make notes in response to the points that I have not addressed at this stage. So recommendation 17.2, 'Social and emotional development for preschool children.' The Australian early development census has been effectively collecting this data about 5 year olds since 2009. This is a very well managed and implemented process and could easily be expanded to a younger age group.

17.3: 'Social and emotional learning programs in the education system.' The national curriculum includes social and emotional learning in the health area. There are many other programs to support this area, including a Shine program and the Keep Safe Child Protection program in South Australia. There's similar interstate, and these programs do not have accountability (indistinct).

17.4: 'Educational support for children with mental illness.' It is in place in South Australia using the effective model of preventative and developmental wellbeing, but highly under-resourced for the demands within the role. Referral pathways are used, but waiting times are prohibitive, face to face access severely limited, and apportion funding allocations and (indistinct) number of sessions (indistinct) inadequate.

The South Australian Department for Education has an excellent program of reengagement with students at risk, of which those with mental illness are high in number. This is called flexible learning enrolment, and I believe Uniting SA have a submission that may provide that service as well. Mission Australia have a report, a research report on the results of their low enrolled students. That's one evidence of what's being achieved in that. The funding model for this is prohibitive because it comes from the school. So in a small school you're losing the funding of that student, which if you're trying to integrate school - them back into school it is very cost prohibitive, but it combines education and health and social services departments. It is known as the 'I can flow model', and having worked at re-engaging students I have personally witnessed

immense improvement from high levels of self-harm (indistinct) behaviours to full engagement with education and training. It was fantastic.

So working with the local or MDO these at risk students reported feeling highly isolated and incompetent and when brought together to engage in meaningful activities and dialogue they begin to make positive changes. One of the best initiatives experience within those role is an art therapy program. Australia is highly dominated by sport and athletic pastimes, and that is even more accentuated in the country. A significant portion of disengaged students prefer creative pursuits such as music and arts. The sense of belonging, method of expression and sense of one's worth emerging from this program was significant.

The success of this program was assisted by my personal appreciation for the arts and my own experience of isolation, lack of creative expression and child abuse related depression. My passion for engaging rural minority groups into productive activity was born from my own circumstance and compassion (indistinct) to see great results such as social anxiety and an early school leaver to an international university exchange student where (indistinct) a degree. It's just so rewarding to see the before and after (indistinct words). When the Federal (indistinct) engaged funding ceased in 2004 I returned to educational settings as (indistinct words). That would be 2014, not 2004.

17.5: 'Wellbeing leaders in schools.' Most schools in South Australia have a wellbeing coordinator student counsellor to undertake preventative model of wellbeing alongside the intervention approach. I believe that's not the case in other states.

**PROF KING:** The difference between states.

**MS MALONE:** Yes. So although I hold a diploma of counselling in South Australia a school counsellor does not need to have formal qualifications other than an education. The role includes a teaching portion for most small schools, which is problematic. I am a member of a local secondary wellbeing coordinators network and there are many responsibilities included within wellbeing role in most sites. Redefining this role would be a significant benefit.

If the preventative model was held accountable requirements at the crisis intervention stage would be reduced. According to the Australian Bureau of Statistics 2017 suicide is the leading cause of death among 5 to 17 year olds, although largely concentrated on 15 to 17 years of age. Should the compulsory intervention be implemented the demand for crisis intervention and (indistinct) would be significantly impacted.

17.6: Wellbeing data has been collected for schools across Australia, particularly at the commencement of schooling in the Australian early development index, and where disengagement levels increase dramatically the middle years of schooling. There's a lot of evidence to show the disengagement process starting from the beginning to the end of middle years. This data has been extensive, but does not appear to have been used to inform practice and therefore benefit population growth. I will just add in there that since

NAPLAN has been compulsory Australia's results in the (indistinct) 15 year old world data collection have declined steadily.

There are so many fantastic initiatives already in existence. There's so many wonderful workers within education that have so much to give. There are so many workers in health, in NGOs that I've come across with my work, so many of you wonderful volunteers, personal people willing to give their time passionately, but our systems don't allow for a positive change. I don't think our systems need to be reinvented. We've had so much - we already have assessment processes, we have programs. They are all there, and they have been researched for evidence. So it's all there.

Positive Schools Network is a great resource of professionals, but also an indicator that change requires boundaries of enforcement rather than encouragement as their progress is voluntary for sites and that cohort is dominated by private schools. In the report there was a question, you know, what should the funding be. So private schools are already voluntarily working on wellbeing improvement and the results are phenomenal; really, really good. If that was a compulsory component for schools because there's benchmarking we would see fantastic results.

I truly hope that a renewed focus on wellbeing within education emerges from the inquiry. I would like to express my gratitude to the Productivity Commission for ensuring the process of public hearing is afforded to people like myself. The opportunity to be heard and valued as a professional with experience working with young people, and as an individual with long term lived experience with mental illness. Thank you.

**PROF KING:** Thank you. Could I ask a couple of questions. It really goes to what I take is one of the key points that we've raised here and made a number of points, but the benchmarking point. I wonder if we've been, from the Commission's perspective we've been approaching the issue or parts of the issues of school from the wrong direction. So we've talked to many principals, many people working for them who say exactly what you say, which is there are great programs out there, but we don't know which ones, there's so many, and when it comes time to choose it's usually principal of next school, what have you got, (indistinct), and go, okay, let's put that one in place and there's no uniformity.

So I guess our approach has been to say, well at a high level evaluate and try and create that uniformity, but I wonder if an implication of what you've said, if you bring in the benchmark, the social and emotional welfare type of benchmarking at the schools, if you change the incentives at that school level do you then need the consistency or consistency to come out of the school saying, gosh, we're down in the bottom third of the list, we've got to do something.

**MS MALONE:** There doesn't need to be consistency because each (indistinct) or each school have different needs. So you're not - one program isn't going to suit every school, and being from a rural school and by also working in (indistinct) schools, part of my work is in Port Pirie which is quite a different population, so schools are categorised as far as

social and economic disadvantage. So the funding model is based on that, and so - yes, very, very different cohort depending on staffing, student numbers. So in a large school the school counsellor that is their role. Within my role I was doing cultural confidence with monitoring the Aboriginal individual learning plans, guardian of the minister, case managing them, students with disabilities, managing them, student voice, so SIC engagement, performing arts, you know, facility management. So there's - and I taught seven different subjects over five years. So that just shows you - you know, like the systems are good, but in a small school that can't work.

**PROF KING:** Yes, and being a jack of all trades.

**MS MALONE:** Yes, which is great opportunity. I now can teach all sorts of things. I've learnt lots of (indistinct) things, but the students are disadvantaged by not having specialist teachers, and so we see an exodus away from rural schools to ordinary schools - well, it's the larger schools. But back to the question about programs, I don't think we need uniformity, we just need compulsion to benchmarking. Yes.

**PROF KING:** So compulsion to benchmarking, is the benchmarking transparency of the outcome, is that going to be enough or we end up with what I suspect has happened with NAPLAN, and apologies because I am guessing, but I suspect what's happened with NAPLAN, and I will just talk Melbourne because that's the area, there will be a number of schools, particularly in middle class and upper middle class suburbs who, yes, the NAPLAN results drive an awful lot of things, because they would be very worried about the benchmarking. I get a little bit worried, but perhaps in less well off areas, that the parents aren't as engaged with things like NAPLAN results and so the pressure goes off the school to perform. So I worry would the same happen with benchmarking, that it would be a great tool for the upper middle class and middle class areas, it would be a great tool for some regional areas, but - I'm trying to think, and apologies if I've got it wrong, but I'm thinking of Elizabeth as being equivalent to say Dandenong in Melbourne, an area which has had a lot of employment, a lot of factories closing down, and so on. Would you get the same engagement there or would it just be, yes, the benchmarking on social and emotional wellbeing, no one pays attention to that?

**MS MALONE:** I think - we already have the data collection as I said. That data is not acted on. So what I'm saying is - and that data is collected in all schools in South Australia. I believe there is - well, there used to be a middle years index in eastern states. I'm not sure what's happening there any more. For a while it was national, nationally, but an offshoot, they keep changing the way they collect it, the age group. So for example in South Australia it was (indistinct) years 6, 7, 8, 9, middle years. They then introduced years 4 and 5 and that became a large portion. So the changes from what's been done the results are just skewed. So the data collection is in itself not a bad - like it's a big process, but the way that it - - -

**PROF KING:** Nothing's done with the data, how it's - - -

**MS MALONE:** It's not a good research of skills, yes. The difference between the sites is not as much of a problem, because they are all following the same Education Department policy, but it doesn't matter if it's Brighton High School down here, which is a high social economic area, or whether it's Port Pirie which is a low social - - -

**PROF KING:** Yes.

**MS MALONE:** It doesn't matter which school, they are still following the same accountability measures which is NAPLAN, fact testing and (indistinct) results. They are the key outcomes, and that's why wellbeing has dropped off, because it's not an outcome, it's not - - -

**PROF KING:** Not (indistinct words).

**MS MALONE:** Yes.

**PROF KING:** Thank you.

**MS ABRAMSON:** I just - thank you for that - had one question. In our model we have really focused on the school being a gateway, so that it's actually the students would be directed to services outside the school as opposed to a model of psychologists or counsellors in schools. What's your experience been of your local health networks and the PHNs, et cetera, and the ability to connect with schools when you need help and services? And it's fine if it's not good, that's why we're asking the question.

**MS MALONE:** Having worked both - both worked within school and out of school I feel like I'm well equipped to answer. So a lot of health professionals get very frustrated when they're trying to communicate with schools. Schools are - like most school work educators are face to face with students most of the time, or they are on yard duty, or they are dealing with a problem, or they are - so they are not contactable very easily, but that's just a different understanding of industries. I would say our system again is quite good, our referral system is quite good. I don't think we need a psychologist in our school. I think your concept of wellbeing coordinators in schools is excellent. That's what we have here and I think it's a great model, because the coordinators are in charge of the preventative and developmental model; perfect.

**MS ABRAMSON:** And we didn't want them to have to have their teaching duties as well. We saw that, we understood that.

**MS MALONE:** Yes. But the other things that are put onto that coordinator needs to be limited so that they can make sure they are (indistinct) those preventative programs. The referral process to psychology is great, but within public schools the specialist services that are free is limited.

**MS ABRAMSON:** Yes. So it's a service availability issue as well. Yes, I understand. Thank you.

**MS MALONE:** The referral system is fantastic, yes, other than needing the parent consent.

**MS ABRAMSON:** Thank you.

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

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

**PROF KING:** Next we have Ellie Hodges.

**MS ABRAMSON:** Thank you.

**PROF KING:** Ellie, if you could just state for the transcript your name and if you're representing an organisation your organisation.

**MS HODGES:** I'm Ellie Hodges, I'm founder and executive director of the Lived Experience Leadership and Advocacy Network, also known as LELAN. We are a peak body for people with lived experience major health issues in South Australia. So I have a statement and answer some questions, hopefully done.

To provide context on LELAN we amplify the voice, influence and leadership of people with lived experience to drive change. We have three main areas of focus; developing the capability and influence of people with lived experience, nurturing organisational and (indistinct) capacity for partnering better with people of lived experience, and impacting system improvement agendas to benefit people with lived experience.

We work with the Mental Health Coalition in South Australia, who you will hear from next, the lived experience community and other organisations on submissions to the inquiry, and we (indistinct) those to provide a human rights (indistinct) to what we contributed. Today though I am here to (indistinct) the lives, perspective and wisdom of people with lived experience, in particular consumers, but note that we have carers involved within our organisation as well.

I want to acknowledge my privilege in being here before you and honour the people who have much to contribute and could say the same things that I do, but don't get listened to for various reasons. Even when I was most unwell I still had choices open to me that others don't and I could speak up because of my education, working within the health services for my whole career. So I just want to acknowledge those differences.

I know that many people waited eagerly for your draft report and it just so happened that I was in Victoria at VMIAC, which is the LELAN equivalent over there, a consumer conference when it was released. I will say that the feeling of the state and territory peaks that were present at that time, six in total, was they left us wanting more from the report

that is being described as a report of the generation. So we (indistinct) a lot of ways of what this could do and the potential, because there's been many, many as you know.

At that time we released a joint statement. We agreed that an urgent generational shift is required and believe that it's critically important to ensure the inclusion of consumers in decision making processes that directly affect their lives. We share concerns that there was no single statement to say that consumers will be an integral part of future directions. We know that the system is broken and we believe that it is not a matter of fixing the system so that it looks similar, we're talking about creating a system that meets the consumers' needs. We know this happens when consumers lead when we're given that opportunity.

I can let you know that the more of the report that I have read the less disappointed overall I am, yet I wish they went further. Whilst there is excellent analysis of the current issues, challenges and opportunities I feel that the solutions offered continue to be through a medicalised clinical lens that I and many others feel replicate these things in the future, and thus would not bring the generational shifts that we want and we desperately need.

There are three main areas that I'd like to discuss today relating to the lens, language or framing of recommendations in the final report regarding systemic advocacy as well as how lived experience is recognised, valued and utilised and may have some ideas for solution around that.

On lens, language and framing, and this is a quote from your report right at the start from the overview. 'Through the lens of participation and contribution this inquiry examines how people with or at risk of mental ill health can be enabled to reach their full potential in life, have purpose and meaning and contribute to the lives of others.' I wonder how different the recommendations would be if the report stated at the outset a different lens and focus of inquiry.

Through the lens of participation and contribution, which I will keep because you are the Productivity Commission and have a particular lens, but that (indistinct) is different and that it says, or was something akin to. This inquiry examines how people experience in distress or crisis and needing a bit of extra help, frequently from the ongoing effects of trauma or factors related to the social indeterminates of health, how they may be supported through a cover (indistinct) and live the lives of their choosing, and how that would shape the recommendations in a different way, if that was centred and forefront and underpin everything that came.

From the outset and (indistinct) deficit framing of our experience would not underpin every analysis or comment in a document. Mental ill health would not be the dominating descriptor and a continuing endorsement of hierarchies of power and vested interest would not persist. It would open the way for consideration of more humane and compassionate understanding of people and their experience, and importantly a greater focus on human rights and social justice. As a (indistinct) system that demonises,



criminalises, coerces and uses power over us, which at the same time tells us we are weak, have something wrong with us or are not doing enough for our country causes more harm than help for those of us accessing services the people who love us and for those that provide the opportunities and services that we engage with too.

On systemic advocacy, or consumer participation as you have labelled it in the draft report, thank you for putting this recommendation in the pulling together the reform section, and with governance and responsibilities. It's critically important that lived experience is recognised at that level. However I would like to highlight the (indistinct) that exists in current investment and practice in this area across Australia, and invite you to supercharge draft recommendation 22.3, enhancing consumer carer participation. Words and language are important, and I believe that in 2020, particularly from a document wanting to be the driver of generational change, we need to be positioning people with lived experience in greater roles and capacity than participate.

National safety and quality service standards speak of consumer engagement and accreditation of health services are linked to that and meeting audits, but that is not enough either. Since mental health reform became more visible in the early 1990s there has been a general statement in many documents and reports that people with lived experience should be involved in all levels of decision making. If we are true to this there are structures that support a multitude of ways to be involved, participate, engaged with would be visible, which they are not and particularly in South Australia. If practices were to have changed in those nearly 30 years now we would be talking about how clinician services in the mental health system partners with people with lived experience at a minimum, bare minimum partnership at each level.

Co-production would be core business and consumer led initiatives would be invested in and learned from. The inequity I speak of in this context is an assumption that all states and territories have a peak body for people with lived experience, and different states have consumer carer involvement and Victoria has both, so does the ACT.

Whilst LELAN currently exists as a peak body with funding this does not come from government and as of July 2021 we will be unfunded again unless something changes. Our first funded project of almost half a million dollars over two years has come from philanthropy, and it involved us asking a university to partner with us. We have good ideas, we do innovate and inspire. We are building up community in our collective voice. We will have impact, yet the South Australian Government does not resource or invest in people lived experience to be involved in systemic advocacy, and (indistinct) broader than LELAN there, just to be very clear.

The gap means that potential for active and meaningful non-tokenistic involvement of people with lived experience in strategic decisions, policy and governance is greatly lacking and maintains a status quo. A lot of talk of symbolic inclusion, yet no actual observable real change in how people with lived experience are provided the opportunity to hold the system and services to account. It is too great a burden for individuals to do

alone, and it makes the power imbalance between bureaucrats, decision makers and people with lived experience insurmountable.

Our value to the system, again not LELAN, all people lived experience, and the undefined dollar contribution that we add to reform efforts is not being realised in current structures and decisions, and this is replicated in other jurisdictions, including nationally. It's not just states and territories that miss out as - we can only engage on state matters, so who's there at Federal level around that. It's a small investment that we would need for this for great benefit. So the five years of funding you recommend would be very welcome, and it would ensure that lived experience and their involvement in systemic advocacy is more than a project, which it currently is, of even the National Mental Health Commission and other agencies looking into this work. A report put out by the National Safety and Quality Commission in 2018 around the attributes of person-centred care gives insights into the benefit of involving people. Experiences of care are improved. Workforce experience of wellbeing and morale improves, which has economic ramifications. There are better outcomes for health and mental health. Safety and quality is improved and there is better value of care because we actually put the right services in place earlier and that saves money overall.

Speaking to recognising value in utilising lived experience, it's also acknowledging that we – the benefit of lived experience around the table and being centred is we offer more than just an experience of so-called mental illness. We have other skills, experience and qualifications. The mental health system is complex, we hear that all the time. We live with complexity. We live with that discomfort. We survive that discomfort. It's how we navigate recovery and our life. We want to be part of the change. We will not run from the change that needs to be made or implementing it. We've been saying for too many years that we are here. We're ready. We want to lead it, as well. We may have vulnerabilities, but we also have immense strength and resources and we want involvement at all levels, where our expertise is not minimised, sympathised, patronised, tokenised, or co-opted. We know the statistics of the impact and experience of mental health issues – one in four, one in two, everyone, is what people go with - and increasingly, people are disclosing their lived experience in work roles, and we are seeing that that is being ticked off as having lived experience at the table. But when they are at the table in other professional roles, they are not centring or prioritising lived experience or making decisions from that frame, and right now, given the state of things, we need dedicated positions and opportunities. We need leadership from others to open the door and enable us this right that we have and to provide structures that keep it embedded and not based on personalities. That too often happens.

There's a politics to lived experience because of the injustice and the oppression that we've had to live with and get through, the harm of the system when we try and ask for help and we get tossed around. We have to double prove ourselves. I've sat at many tables and everyone else has a fancy title, a fancy suit and a big paycheck. It comes around to my introduction: "I'm Ellie and I'm the Lived Experience person", as if that is all I am. Another co-option happening right now is around co-design and coproduction. We need this as standard practice and what we have at the moment is a lot of words and

some goodwill – some of the time – but it is not happening. So thinking about what we could do beyond this, a couple of years ago I was – did some consultancy with the South Australian Mental Health Commission looking at how we strengthen pathways for lived experience voice, influence and leadership. I spoke to advocates, I spoke to commissions around the country and a couple of peak bodies, and these are some of the main headings of what was in the report derived at that time:

*Structures beyond individual engagement are needed to effectively influence systems of practice. We can't rely on individuals. We need structural systemic advocacy embedded. Any structures decided upon must suit the unique context and circumstances of where they are being considered and for what purpose.*

When the voice of lived experience is not embedded within systems, it can be easily lost or co-opted into the more dominant way of being. It's hard for peer workers to be in a team where clinicians lead, and there's eight. Power imbalance again, which I – pathways and structures should not be restricted to a sole focus on lived experience or low level roles. We need to live the - all levels. Structures and pathways must focus on building capacity and capability of people with lived experience and others.

Coproduction is appealing to many as a supportive structure for lived experience, voice and influence. It's still very much a work in progress. Pathways and structures need to create space for all people with lived experience. Not the privileged ones, not the white ones, not the educated ones, and not those with anxiety or depression. We need it for all people and all experiences. Lived experience leadership need to be addressed. Organisations have a responsibility, and the system has a responsibility, to ensure environments are conducive to lived experience voice and people with lived experience thriving in their space. If a workplace and a work culture makes being present there as a lived experience worker difficult, it's not because we have failed or are not strong enough, which is what we are currently told. It's actually the culture of the organisation and the system that is not safe for us as a workplace.

Structures set up solely for the inclusion and agenda of people with lived experience are an important part of the engagement and involvement landscape. A peak body or central organising entity for lived experience is the preferred option for strengthening the voice of lived experience by people with lived experience and others. Peak bodies more easily gain access to decision-making tables that are out of reach to individuals. There's a different accountability mechanism that can be inbuilt into the system by having organisations for systemic advocacy solely by, for and with people with lived experience. Peaks provide a pathway for collective voice that's harder to shut down. I feel like I should stop.

**PROF KING:** Just a point of (indistinct) – so the report you were referring to at the end is – do you have the full name of the report?

**MS HODGES:** It's Pathways to Strengthening Lived Experience, Voice and Influence in South Australia.

**PROF KING:** Okay, and that's available?

**MS HODGES:** No, but I have Lawson's email.

**PROF KING:** If you could email it through that would be fantastic.

**MS ABRAMSON:** Well, the irony – firstly, thank you for such an eloquent presentation. It was really very, very informative. Examples of where you think it's worked well – so where lived experience has been taken as a serious part of the coproduction or co-design, not – as you said, they go around the table and 'oh, you're the lived experience person'. So do you have some examples of governance where you think it's worked well?

**MS HODGES:** One example in South Australia, which was double-edged in some ways, is the Lived Experience Telephone Support Services. The design of that was coproduced, but then when it came to the funding of it, it changed, and there was some difficulty around that. So what we find sometimes here is that services may commit to a coproduction process, but then decision-making, they don't agree or then they don't fund it. Where it's been done well, I think it's not in government services. It's in – NGOs are doing it better, partnering and walking alongside people to engage them and talk to them about what would work, what would hope. It's when there's more lived experience staff on a workforce, where they can shape things and when they get into decision-making roles.

**MS ABRAMSON:** Although it's interesting, you made a good point, I thought - amongst a number of good points – about lived experience, that just because someone has lived experience, it doesn't mean that they bring it to the role that they're actually doing at the time. So it's actually got to be a combination of a person tapping into that experience in their day job, for want of a better word.

**MS HODGES:** Absolutely. If we look at Beyond Blue, Georgie Harmon is now out publically as having lived experience. I'm sure that when she's at the table, she's there as a CEO. She may have a more compassionate, understanding and accepting response, but she is not making decisions - - -

**PROF KING:** On that basis, yes.

**MS HODGES:** - - - from that place. We need it as well. It's not one or the other, it's both.

**MS ABRAMSON:** If you can – if there are any examples that come to mind in or after our hearing, just – if you could email Lawson, we'll have a look at them.

**MS HODGES:** And it's also not just coproduction but the lived experience (indistinct). So in Queensland, there is a service called Brook RED that provide housing and recovery and group support to people, which is a completely peer organisation.

**MS ABRAMSON:** That sounds excellent.

**MS HODGES:** So there are examples around country that we can learn from.

**PROF KING:** Are there – sorry, last question. Are there examples in the clinical space? Sorry, I know that's putting you on the spot.

**MS HODGES:** No, there are. I would want to think about that, yes.

**PROF KING:** If you're able to think about that and if you can shoot through an email, that would be fantastic because as I see it, it appears that the cultural gap is biggest in the clinical space and if we can get across that gap, that would be fantastic.

**MS HODGES:** And I think a complex figure around clinical as well is – so a lot of it was happening on the side, and then we got funding, so it's now my paid day job. But before that I was also a therapist, and our - about lived experience, so people would come to me specifically because I had that. And because of my speciality, which is my lived experience, my trauma and eating disorder, the Statewide Eating Disorder Service had very big questions about my ethics and concern.

I would suggest that my ethics, I had to think more about them and reflect more than most people as a practitioner about how we use lived experience. So there's stigma and discrimination that happens where clinicians don't feel same to come out, or how to use that in practice as well, because of judgment. I know multiple people within SA Health whose jobs have been made very difficult around this. So yes, I can certainly add some examples.

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

**MS ABRAMSON:** Thank you.

**PROF KING:** Next we've got Geoff Harris.

**MR HARRIS:** Did you say we've got tons of time?

**PROF KING:** No, it's just that we're running about 20 minutes late. We haven't started hitting the points yet where we say oh God, we need to stay overnight. If you're able to state your name and any organisation you represent for the Commission.

**MR HARRIS:** Yes, I'm Geoff Harris from Mental Health Coalition of South Australia, and we provided a submission post draft. So I'm presuming that you've seen that and have read it, so I won't be - - -

**PROF KING:** No, sorry.

**MR HARRIS:** And also I work with Ellie around the submission, a joint submission, particularly focused on human rights aspects from some consultations that we had.

So to kick off, to follow on from Ellie, I would say funding, lived experience, peak bodies is critical. It's critical to having capacity for lived experience voices to get organised. I think the history of inclusion of lived experience voices in Australia has been one of just kind of capturing that voice into processes where people can only hear a small amount of that voice and can't deal with the bigger issues that people are trying to bring to the table.

So I think that's one of the key things that can move us from that kind of consultation mode to one where people with lived experience have more resources to talk about issues and develop policy positions and avenues. So I think it's critical.

Also one of the questions you asked about lived experience in the workforce, I think some of the people following me could really talk to you a lot about that. But in the mental health coalition we've done a fair bit of work in the lived experience workforce in South Australia and a lot of it is looking at what are the roles, what are the skills, what are the capabilities and making sure that it's not, as Ellie was concerned about, like people who have a job and then say down the track, oh, I've got lived experience.

**MS ABRAMSON:** Yes.

**MR HARRIS:** It's more talking about within the workforce in mental health, what are the kinds of roles where lived experience is valuable, what's the value of lived experience, how do you bring that into the roles and make an impact. We know there's really good research that is effective, but there's also research that says, in the wrong environment, the lived experience worker can't do their work properly.

You asked a question about the clinical cultural gap. I think that goes to a lot of the work that we did in our submission around the role of psychosocial support.

So maybe to move into an opening spiel, where we were thinking is we really appreciated the Productivity Commission's focus on broader outcomes than just mental health outcomes or just health outcomes. So the issues about housing, about employment, about reduced contact with justice systems and so on, is really critical. So the human rights aspect to mental health is really broadened, and I think that's at the heart of the cultural gap, because where most of our mental health services have come from is a history of a medical model, which by definition is much narrower than a human rights agenda.

So what I've seen happen over a considerable period of working in mental health is ideas that are about, you know, human centred, person-centric, supporting people to improve, things like housing, employment and so on, have tended to come, if they're pushed into the mental health system, they get in there, just, and then at the first opportunity of reducing expenditure or focusing on our services, they're the kinds of things that are chucked out because I think the cultural dominance that you're referring to is much more about a medical model, preference and strength in those services and how they're formed and designed, and if you were looking at a departmental sense, you'd say the health department just wants to focus on the health bits, doesn't want to deal with housing.

So a lot of our submission was about so how do you bring that human rights aspiration appropriately into a mental health context. So we are arguing that the gap in psychosocial supports that you identified across the country, which is huge, is a really large part of that problem. Like solving that gap appropriately will help I think move mental health services into a better balance between health outcomes and social outcomes, pushes more towards a – like we need to move more towards the social model of mental health, and I think an investment that's smart in psychosocial supports could do that.

So that's where the psychosocial supports won't necessarily provide housing, but for people who have really complex needs, it might be providing some support for people to access those housing programs they need to access. Or it might be the thing that gets them over the line of getting a tenancy by being able to prove they've got the support that makes the landlord comfortable, so there's those kinds of things.

So I think the psychosocial component can be a bridge to supporting people to get effective support from other sectors, but also I think it's a bridge back into other mental health supports as people need them, particularly things like GPs for example, I think – I'm not sure whether you've had any submissions from GPs directly, but often what we hear is things like the – that they struggle to deal with mental health because people who have severe issues often present in a episode illness, and so that's a crisis for a GP to deal with. And their main pressure point is getting that person into more acute services, and they don't really have the time to support people around the other issues, like housing or relationships or whatever.

So I think that's where we've tried to present an approach that talks about how to fill that psychosocial gap in a way that can deliver more of those human rights outcomes, and I think trying to move away from a concept of psychosocial supports, just reducing hospitalisation rates or just saving money somewhere else in the mental health system, but actually delivering benefits that are in that human rights frame.

**MS ABRAMSON:** In fact, it's very helpful, Mr Harris, to have this conversation, because one of the things that came across in our report, which was unintentional by us, we had a model of stepped care and we had psychosocial running underneath it, and it gave the impression that we always thought that it was a clinically driven link to psychosocial. We didn't think that. We understand that that's how it came across, but the issue that we've asked a few other participants - that we struggle with is that psychosocial supports are often made available, because they're rationed funding things, on the basis of a diagnosis or a medical entrée into the system, and we had a conversation this morning around, well, what other models are there so that you can get psychosocial support and it's not dependent on the diagnosis or, you know, on a medical view of the world.

**MR HARRIS:** Look, a really good starting point to that is to look at the scale of the unmet need and try to fund to meet that gap. Most of my experience has been at the more severe end and so I wouldn't presume to speak to how to do it around low and moderate,

though I think, if you actually are able to fund to the capacity you think is required and not leave any unmet need – you know, psychosocial space, then you’ll solve a lot of those problems of rationing, and we had that very conversation this morning with a senior in person in the state department of mental health – or Department of Health, and that’s what we’re trying – like, in that Mental Health Services Plan in South Australia, that’s one of the things we’re trying to wrestle with, is how do you make the access point not feel like it’s a rationing point where you only qualify by being really ill and make it more of an access point where you feel like, yes, that person I’m talking to is here to help me and they’ve given me some options, and examples would be things like if you go through a referral process to, say, a clinician through a GP and your wait time is six months, what that effectively says to you is that your life is on hold for six months until you see this person who’s going to sort out your problem, whereas there’s lots of other things that would be really helpful, but our systems tend not to do that. So one of the – so Ellie talked about the Lived Experience Telephone Support Service and I would say that’s a really good example of how we’ve been involved in a co-design process to try to create an access point that is helpful. It’s run by people with lived experience. It’s got a counselling approach rather than a clinical kind of approach. So it’s, you know, ‘how can we help you’ as opposed to, you know, ‘tell me your problems and I’ll tell you the solution’. So it’s kind of an interesting example, and we’re talking with our state mental health people around, well, how can we do something like that for the psychosocial services that the state’s still funding here? So I’m not sure I answered your question.

**MS ABRAMSON:** No, but you know what? It’s helpful to know that everybody else is thinking about it as well, because that’s the thing – we’ll have a look at some of the programs that have been mentioned, too.

**MR HARRIS:** So I think – so part of why I think that approach is useful is that people who are looking for help – you know, sometimes it’s – something that’s really important is having someone that’s reassuring on the other end of the line, and sometimes the options that are available, they’re not very expensive. So it’s information or it’s ideas about options, it can be peer support groups or training programs. So it’s not all just about an intensive service that’s really expensive and – you know, things like Clubhouse or GROW, examples of services that are really valuable, but apart from the promotion by those services themselves, the system doesn’t actually refer people effectively to those programs.

**MS ABRAMSON:** No, that’s helpful, thank you.

**PROF KING:** What – so I mean, the services have to be there to be referred to, and that’s a problem at the moment.

**MR HARRIS:** Well, some are already there. But the rationing thing is partly a cultural problem, I guess, of all services being seen as part of that clinical continuum. But it’s also just – yes, not having enough resources to be able to deliver to the population as appropriate.



**PROF KING:** So for a person down the more severe end, having an appropriate care coordinator that stands both the psychosocial and the clinical, does that – would that help create the right pathways? So – but you don't have somebody – so you don't have to go along the clinical track to be able to access the psychosocial – so you have a care coordinator and your clinical needs may be low at the moment, but you have psychosocial needs which are much higher, and that person, because they stand that space – they deliberately stand the space, they can say, 'let me put you in contact with this service here'. It may be housing, it may be support (indistinct), support of education, it may be employment support. But are we thinking in the right direction in going down that way?

**MR HARRIS:** Absolutely, and that's where – like, in our submission we talked about care coordination as being a broad thing and I think probably the pathways to clinical care are really well known, you know. You know they're numbered around. If you want to get to hospital, you know where ED is. You know how to contact your GP, and that's the first point. Like, it's not as if people don't know how to get – how to contact clinical care. Whether they get it or not is another thing. But the care coordination role I think – so most of the stuff that I've seen in policy has only picked up part of that coordination role, and that's the clinical part. So – and often that's sort of motivated by things like who pays for what service and having different ways of accessing the services, and so - - -

**PROF KING:** It's probably more a reflection on the disjointed structure of our clinical services than anything else.

**MR HARRIS:** Yes. A lot of it's the Commonwealth's state of mind, basically, and moving people who – like, in the best way, people who've had that severe actual illness and needed crisis care but now they're doing quite well, transferring them to the care of a GP for their clinical needs. But in terms of the psychosocial supports, there isn't a mechanism to do that. So services like Partners in Recovery were very good at providing that care coordination that was missing, and so it's been quite disappointing to see that disappear from the landscape. But that care coordination role in the psychosocial – in the broader needs is just not there, and I don't see how to effectively recreate that within clinical settings at the moment. Like, it could be done, but it's more expensive than looking at other alternatives and I think that's where, when we're looking at the proposal around commissioning, we're very interested in how whichever model comes out – like, how do you prioritise things like psychosocial supports? Because it's likely that in some of that kerfuffle in whatever change process it is – sorry, I'm getting a bit technical with 'kerfuffle', but - - -

**MS ABRAMSON:** We know what it means.

**MR HARRIS:** Just in that change process, it's easy to revert back to a narrower model of care and certainly, I think, that's what we've seen with NDIS – you know, with the NDIS in a policy sense outside of NDIS. Regardless of what you think about NDIS itself, outside of it, it's meant that often state and federal governments have been absent from thinking about psychosocial needs of people because NDIS is coming. That's going to

deliver, and there's – you know, so it's been a really interesting reversion back outside of NDIS to a much more narrow - - -

**PROF KING:** Clinical.

**MR HARRIS:** - - - medically focused model as opposed to the social models that we've been going towards for the last 30 years.

**MS ABRAMSON:** Do you see any of the PHNs operating in that space in terms of commissioning or working with NGOs for psychosocial supports?

**MR HARRIS:** Yes. The issue, though, is the directives they have from the Commonwealth and the quantum of money they've got, aside from anything else, and so – and PHNs across the country are wrestling with that problem. Some better than others, but at the heart of it is – like, there's been some rhetoric to say, you know, that PHNs are delivering – you know, have got funding from the Commonwealth to deliver in that space. But practically, they haven't got a lot of money to deal with it and the Commonwealth programs that were there - like PIR, PHAMs and Day to Day Living - they are much smaller than they were before because the money has gone to NDIS as per the plan, but it means that outside of the NDIS, as you've identified, there's very little there and – like, one of the concerns about those kind of remnant programs is when you take them out to country areas, they get really tiny. You know, the tiny numbers of workers over the large areas. So scale is a problem in that, as well.

**MS ABRAMSON:** Thank you.

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

**MS ABRAMSON:** Thank you.

**PROF KING:** Now, we've got a number of people from UnitingSA next. (Indistinct words). I should stop talking.

**MS BAMENT:** Are you ready?

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

**MS BAMENT:** That's fine.

**PROF KING:** If you can introduce yourselves, and the organisation you're representing for the transcript, and then any opening comments you'd like.

**MS BAMENT:** My name is Danielle Bament. I'm the manager of mental health services for UnitingSA, and I am here representing UnitingSA.

**MS ROBELIN:** And I'm Keryn Robelin. I coordinate with Lived Experience, 100 per cent Lived Experience Team for both NDIS and UnitingSA.

**MS ABRAMSON:** So, we'll try not to interrupt.

**MS BAMENT:** Yes. So, UnitingSA is a leading provider of community mental health services in and out of South Australia. We work closely with The Mental Health Coalition, and we've been providing psychosocial support services across the state for over 20 years. We've provided a written submission in response to the Commission's draft report, which includes a series of 28 recommendations in response to the key (indistinct) for reform. Today, however, we'll be focussing specifically on our recommendations in relation to the peer work force, and the critical role of people with lived experience play in supporting the recovery of those living with mental distress. We would describe UnitingSA as an approach around the engagement of people with lived experience, and the delivery of psychosocial support services, and the substantial benefits of this approach to support the recovery of people experiencing (indistinct) distress.

Throughout our presentation, we will be using the terms 'peer support worker' and 'lived experience worker' interchangeably. UnitingSA defines a peer worker as someone with personal, lived experience of mental distress, who is skilled in joining on their own journey of recovery to support the recovery of others. So that's an important distinction, it's not – I think, as a previous speaker sort of touched on this, it's not just about having lived experience, it's actually about having a skill set, and drawing on your lived experience to support the recovery of others.

We recommend any reforms to the mental health and supporting systems recognise the critical role of peer workers in supporting people's recovery, and that this approach is valued as at least equal to that of a clinical interventions. To this end, we note the recognition given to peer support work in the Commission's draft report, and the recommendations in relation to strengthening the peer workforce, and placing peer workers in the emergency department alternative models. We urge the Commission to go further with these recommendations, however, and call for a substantial increase investment and availability of peer support services.

In order to improve the health and wellbeing of people living with mental health issues in Australia, peer support should be readily available to all people seeking mental health assistance above and beyond community providers and emergency responses. There is a need to vastly improve people's experience with care in all clinical settings, and peer support must be widely available option to work alongside, or as an alternative, to clinical interventions. Recognition of the trauma suffered from abuse, restrictive practice and coercion across the gamut of clinical settings needs to be reflected in the Productivity Commission's findings and subsequent recommendations. Ensuring access to peer support workers in all care settings will go a long way to ensuring that people's human rights are upheld, and significantly reduce the risk or re-traumatisation, as tragically so common as a result of clinical intervention.

Over the past two decades that Uniting has been delivering community mental health services, they have continued to invest in grow up their work force. In 2018, we were the first organisation in South Australia to be accredited against The Mental Health Coalition's lived experience workforce standards. In 2019, we were awarded The Mental Health Coalition's organisation award for lived experience workforce. Currently we're partnering with the University of South Australia to progress a PHD to research and advance the mental health sectors understanding of the role, and impact of the lived experience workforce in the mental health sector.

With the rollout of the NDIS, we are seeing significant diminishing of peer support services, such as personal health and mentors program. Geoff touched on that service previously. It no longer exists as a program. There is an extension funding for the rest of this financial year, and then it will essentially cease. So there's no (indistinct). Our concern for the very real risk of a diminishing peer workforce with the rollout of the NDIS, we've created a new program to provide psychosocial support to NDIS recipients living with severe mental illness, delivered by 100 per cent lived experience workforce.

The program has recently been independently evaluated by the University of South Australia. The evaluation found quality of services delivered through this program were in line with best practice standards in recovery orientated care. However, the evaluation also recognised significant challenges in operating best practice psychosocial services under the current NDIS pricing regime. We are reporting that based on independent financial analysis a 25 per cent gap in funding.

UnitingSA operates on peer support services under recovery model of care. Through this model, peer workers give hope to people living with mental illness, through their own journey of recovery. They provide support to people to overcome personal, structural and systemic barriers to their recovery. Under the recovery model of care, recovery means walking alongside a person to help them achieve personal agency and a satisfying life, even in the presence of symptoms, so that their human rights are upheld.

I'm going to pass over to Keryn, now, who will describe the value of peer work, and the way in which this is realised within the team that she leads.

**MS ROBELIN:** Thank you. So, a lot of lived experience recommendations have been brought to the table today, so that got us thinking about what we mean by lived experience. When we first created the team, we considered what it was of the purpose of why we were going to do what we were going to do. So when it came to having 100 per cent lived experience, we wanted to challenge work culture. We wanted to actually see if we could dominate, I suppose, the mindset. And the guidance NDIS gave us an open window to be able to offer a hands-off approach, rather than a top-heavy governance of how we practice, so like kids in a candy shop, we said, 'Well, it's got to be 100 per cent lived experience.' But this was drawn from individuals, and their family members. It was something that they requested, it was part of the co-design that they were all involved in, from recruitment right through the interviewing, interview questions, right through to who was chosen, and holding us to account of our practice each day.

The things that didn't come up was, not one of our single people asked for a peer worker; they didn't know what a peer worker was. And they didn't know what a lived experience worker was. They didn't ask for anyone with a PHD in research of mental health distress, but they said, 'I just want someone who gets it.' And something in regards to lived experience is – something we really get is that mental health distress always comes after life impact has got to a point that it can no longer be handled by one individual.

When it comes to lived experience, I had a big think about this, and for me, lived experience and a lot of my colleagues that don't don the badge of lived experience say, 'Well, we've all got lived experience.' And I 100 per cent agree, but that is, for me, walking through what is grown from life impact, and when you think about the expertise of working with lived experience, for me, it's more about the expertise, the skills and intentionally using it to benefit another person for their growth. It is now their time. So we'll go through form story to skillset.

In the recent spate of bushfires, I think a lot of people were faced with choices to either evacuate and make drastic decisions on behalf of their own wellbeing. They knew that they were facing impending loss such as housing, stability, maybe their livelihood. Some people chose to stay behind, some people chose to wait and see what CFS could do. Metro Fire Service get paid for their job, they are experts in the field. They know less about what the voluntary fire service know about actually living in the terrain and living every day. I would like to use that as a parallel for lived experience, expertise. Recently, I was lucky enough to spend some time with one of our people. We call them our team members because they're right alongside. We don't call them our patients. They're not our consumers. We are privileged to be invited into their story. We were in the car, and the person turned to me. They had been in one of our other services prior which we've learned from, and they said, "You're from UnitingCare Wesley". That's our former name.

And I said, "Yeah, UnitingSA", and he goes, "Well, why are you so different?", and then he answered his own question and said to me, "It must be the training. You must be trained differently", and what I offered was – I said, "Well, when I think about it, we all get trained the same or we're all offered the same training at work, but all of our team were once in your shoes and were given the same message that, just like every single person that we've spent time with, for me, for the past seven years, told, 'This is it for you. It's a dead-end. Thanks for trying out adulthood. It's not going to work. You're going to be given a disability support pension. If you're lucky, you'll go on a housing waiting less, or for now we'll just pop you in a boarding house'", so they were real ending statements.

And I shared with him I was given the same, just as my colleagues, just as their team had, but we just challenged that, and we actually explored what that actually meant and came up with our own truth. Something about the lived experience workforce which I've heard people requesting for here that we already do is inclusion of the lived experience voice in every training that we offer, to the point that this year a parent of one of our individuals

that we spend time with will be teaching us on their experiences and also their loved one. We offer when there will SA health cuts recently – and over 30 per cent of our staff lost their job – we offered peer support.

While I was sitting up the back, I received an email from someone that doesn't work in our mental health services department asking if they can connect with our team rather than the employee assistance program to actually counsel through some situational stuff that's going on in their life right now, and so we responded to that. We're just offering space and really big ears. So I've been in the game for seven years actually, and with people at other services said they can't spend time along because the process doesn't fit, they don't fit in the box, their life is extremely blob-shaped, and so in doing that I think we've learnt a lot. In the seven months that my pilot has been running we have had buy-in from our team, not only into the practice, but into the culture and holding themselves account to each person they spend time with, especially family members.

The differences that we've seen is they're no longer asking what's wrong with me. They're stating now being able to define what's happening for them. Labels are turning into identity. Grief is turning into hope or an absence of hopelessness. Success is defined by the self and by family members. We celebrate those successes rather than ruminating on risk assessments, and waiting rooms has turned into breathing room. So in regards to that, what we've worked out in holding ourselves to account, learning from the past and changing those things we've learnt that culture is necessary, that training and accreditation of the lived experience skillset and expertise needs to be held up higher.

That's in some of our recommendations. We know that connection and codesign can't be done without it. It's why both Dani and I are here today sharing this delivery. So if I take us back to the bushfires, if your house was burning, would you want someone that has written a thesis on burning houses, or would you turn to a person that has lost just like you and wants to be with someone who really gets it? I will hand it back to Dani now.

**MS BAMENT:** So, as Keryn referenced, peer support work with as a sole support in a person's life alongside clinical services can make an incredible difference to the quality of care they receive and, subsequently, their quality of life. When making recommendations about system reform and investment in mental health services we urge the Commissioners to value peer support as an essential, highly effective and cost effective intervention with human rights values at its core that should be widely available to people wherever they are seeking assistance to overcome their distress. We urgently need to see the reinstatement of peer support services, such as Fams, that have been lost and continue to be diminished by the loss of state and federal funding with rollout of the NDIS.

**PROF KING:** Thank you. I'll just ask one to clarify, sorry, Julie. Just on the training for the peer workforce, so you said two things, Keryn, that I just want to make sure I've got clear. So all training should include the lived experience aspect.

**MS ROBELIN:** I believe so. If we're going to be looking at facing the life impact alongside an individual, we need to understand what that terrain is.

**PROF KING:** Okay. And lived experience workers need to have the right skillsets, but I took – and I'm not sure if I've got this right, but I took from what you said they don't need different training to people without lived experience. It's the same training, but the training has to be right for everyone, if I can put it that way.

**MS ROBELIN:** Did you want to respond to that? I've got an answer for me, and when it comes to that I believe that if I was to go to a hair salon and I went to Just Cuts for having some colours, I have three levels of colours in my hair, I'm in the wrong salon. I would be looking for someone that has done about five years minimum in hair colourisation. I would not risk myself in the hands of someone that had been given a watered-down version or a short course version of what takes years to actually learn from.

So I believe that the expertise, if anything, should offer resources to future training of those that are operating effectively. We've got Cert IV in Peer Work here in South Australia. That's an accredited course nationally, and that was derived from peer champions and we codesigned. So it's already in place. I do think that if you are going to put on the badge, you need to have gone through a gateway of understanding what that means, the significance that it is not your story, it is not your time and how you're going to use those tools that you've drawn.

**MS BAMENT:** So in relation to our workforce development and training, we have, regardless of whether someone is in a peer work position or community support worker, a minimum Certificate IV in Community Services or Mental Health. What the – I guess the standards around peer workforce and that as a skillset is still something that's developing nationally, and we're very keen on participating in that. So in terms of the training, yes, there is a base level of understanding mental health and people living with mental distress. For our peer workers we certainly do value very highly the peer mental health certificate because it trains in the skilful and mindful use of their lived experience.

However, their availability of workforce with that certificate is really small and we can't fill our positions with that accreditation alone. So we through our recruitment – that's a key part of recruiting for peer workers is associating a person's ability to use their lived experience in a purposeful and safe way. So we do that through recruitment, and then it's developed through supervision. We don't have any specialist training at the moment because it's not as valuable outside of the peer Cert IV.

**PROF KING:** Thank you.

**MS ABRAMSON:** No. Good. Thank you very much.

**PROF KING:** Thank you then.

**MS ABRAMSON:** We will let you get back to your day jobs.

**PROF KING:** Next person is Melissa, Melissa Raven. So welcome, and if for the transcript you can state your name and your current (indistinct).

**DR RAVEN:** Yes. I'm Melissa Raven, and I am a research fellow at the University of Adelaide and the Clinical and Ethical Mental Health Group.

**PROF KING:** Any opening comments you would like to make?

**DR RAVEN:** I'm happy to launch into my presentation.

**PROF KING:** Yes, please.

**MS ABRAMSON:** Feel free to.

**DR RAVEN:** I'm torn between looking that way and looking this way, and so I'll probably look up, swivelling my head quite a lot. I have three key messages to try and put across today, and I see what I've written right at the front. The first key message is that the decision to exclude social determinants of mental health is very problematic and I think it calls into question the claims that the recommended reforms will improve population mental health and population wellbeing, and I'll elaborate on them shortly.

My second key message is that there is a taken for granted assumption that treatment is the answer, that it just needs to be the right treatment in the right quantities to the right recipients. This assumption is not evidence-based at a population level and in fact there is considerable evidence that challenges it.

My third key message is that many economic analyses, including several analyses that are cited in the draft report, and some of the analyses in the draft report, include problematic, non-evidence-based assumptions or assumptions that are based on very weak, problematic evidence.

So moving to elaborate on my first key message, I think the decision to exclude social determinants of mental health is very problematic, and as I said, it calls into question claims that the recommended reforms will improve population mental health and population wellbeing. The draft report explicitly rules social determinants of mental health out of scope; on page 123 it acknowledges the social and economic circumstances of people's lives having substantial influence on their mental health.

“While acknowledging this important link, this inquiry focuses on improving the way systems and government services can support people with mental illness across all walks of life” – and I have no problem with that – “and contribute to population wellbeing, and that is what I question.

For example, while this inquiry has examined how to improve accommodation options for people discharged from mental health in-patient services, and strengthen mental health



services for people without stable accommodation, broader community-wide problems of homelessness and housing stress will not belong to this inquiry's scope.

Additionally, the draft report specific rules the adequacy of the Newstart Allowance out of scope, and it says, "Where the payments are at a level that represents an adequate safety net is contentious, particularly in relation to Newstart, but as noted in section 40.5, this concern is not specific to people with mental illness and is outside the scope of this inquiry".

I think it is very problematic to take the stance that things that are not specific to people with mental illness are not important determinants of mental health.

**PROF KING:** Because I think your interpretation of why we didn't go there is incorrect. We don't believe they're not important determinants, it's simply that we have to draw boundary – so we do an entire inquiry on the right setting of Newstart. We could, and in fact we have, done an inquiry where we have certainly hundreds of pages on public housing and the ways to improve public housing, the property – or climate change, we haven't done climate change.

So it wasn't that we don't think they're important, it's just that if we didn't draw a boundary somewhere, then after 18 months we wouldn't have actually addressed a lot of the issues that we see as being core. So I understand your position, and we had to make a judgment, and I understand that some people will say you made the wrong judgment, particularly on climate change, which I don't think we even mention in the report, there's been a lot of criticism on that. But I'm not sure what else we could have done.

**DR RAVEN:** Yes, I understand that, the potential scope is an extraordinary broad one. It would not be possible to focus on everything. However, what is problematic is that having made that decision, there are these claims that the reforms will improve population mental health and population wellbeing, and I just don't think those claims are terribly accurate.

Also I note that the Royal Commission in Victoria, when it was first announced it was an inquiry into the mental health of Victorians, but quite quickly it narrowed down into an inquiry into the Victorian mental health system. So I think it is more appropriately benched, I think – in the final report I would like to see claims about improving population health gone – in fact I actually would like some acknowledgement that this – the proposed reforms are not going to have an appreciable – or are unlikely to have an appreciable effect at a population level. Anyway.

Actually, that sort of makes relevant sort of my next few points. However, I'm still going to say I think it is hard to think of a better opportunity than a Productivity Commission inquiry into mental health to evaluate economic social determinants of mental health. I think it is a – from my perspective it is a lost opportunity, and that would include the Newstart Allowance and other welfare payments which affect other social determinants of mental health, such as housing insecurity and food insecurity, and tend to have a snowball effect.

Again, some of my next stuff has sort of become irrelevant. I would like to say though there is abundant evidence about the importance of social determinants of mental health, both in Australia and internationally, but unfortunately it just does not get the recognition that it deserves, that it warrants.

But I will draw your attention to a submission by some other people, submission 157 by Leach and colleagues – Liana Leach and Lyndall Strazdins and colleagues, which does focus – it focuses on social determinants of the health of workers, which of course has economic implications. They draw on the research of Geoffrey Rose about distribution of disease burden in the population, and I'm just going to quickly read an excerpt from their submission:

“High risk individuals are only a small proportion of the overall population and so account for a small burden of disease. It is the people at the centre of the distribution” – as in a graphical distribution – “exposed to only a small element in risk, i.e. low level symptoms, who are responsible for the largest burden of disease, thus the greatest social and economic benefits will only be realised by shifting the distribution of risk in a positive direction”.

By that they mean shifting the mental health of the population as a whole a little bit in a positive direction. So it's not making massive changes to a lot of people, but just a little bit. And because there are so many more people to the left of the distribution, that can have quite substantial aggregate effects.

The last thing I'm going to say about social determinants of mental health is, unfortunately, research into social determinants of health and mental - including mental health are complicated by the fact that many factors and many outcomes are interrelated. There tend to be relatively weak links between any one factor and any one outcome, and this makes it hard to produce strong evidence.

However, small changes and multiple factors can have large aggregate effects in relation to multiple outcomes, including other factors. For example, poverty, unemployment, housing and security, and permanent security influence not only physical health and mental health, but also influence educational outcomes, vocational outcomes, and crime, and they all potentiate one another. So, in the diagram, there's arrow going in all directions.

Okay, one last thing. Some useful research comes from so-called natural experiments, including abrupt economic changes, that have demonstrated that mental health and suicide rates are significantly influenced by abrupt changes in social determinants. In America, Costello et al, discussing the establishment of a casino, of all things, on a North American Indian reservation, which created jobs, reported that - and then come intervention, they leave the employment generated by the casino, and then come intervention that moved families out of poverty for reasons that cannot be ascribed to family characteristics had a major affect on some types of children's psychiatric disorders, but not on others.

So it wasn't a - you know, it wasn't a panacea, but it certainly helped the community. And on the other side, financial austerity has increased suicide rates, and Greece in particular has found that - well, suicide rates in Greece and other European countries have been on a remarkable upward trend following the global recession of 2008 and the European sovereign debt crisis of 2009. So, okay, enough about social determinants. I mean, you know, maybe I'll be lucky and in a year or two, there will actually be an inquiry into the social determinants of mental health. I would love that to happen.

Right. My second key message is the assumption that treatment is the answer at a population level. I'm not saying that treatment is not the answer for a lot of individual people. But there is a taken for granted assumption that treatment is the answer generally; that it just needs to be the right treatment in the right quantities to the right recipients. This is not evidence-based at a population level, and in fact there is considerable evidence that challenges it.

Now, first of all, there is no population evidence that directly demonstrates that increasing treatment at a population level increases population mental health. Now, I'm taking a bit of a risk by saying that, because obviously I don't know all the evidence.

**PROF KING:** All the evidence, okay.

**DR RAVEN:** But I have searched. I cannot find evidence at a population level, and there is mounting population evidence that increasing treatment does not increase population mental health, and I'm pleased that, in the mental health literature, there is increasing questioning of the assumption that scaling up treatment will significantly improve population mental health. There have been multiple studies from Australia and other countries that have produced evidence that that is not the case.

And some of these articles, quite usefully, have the answer in their titles. Mulder et al from New Zealand published an article in 2017, 'Why has increased provision of psychiatric treatment not reduced the prevalence of mental disorder?' Bastiampillai et al, from here in South Australia, 'Has the UK improving access to psychological therapies program and rising antidepressant use had a public health impact?' The answer is no. Tony Jewel, here in Australia, 'Australia's Better Access Scheme. Has it had an impact on population health?' The answer is no.

Furukawa and Kessler, last year, published an article, 'Why has the prevalence of mental disorders not decreased as treatment as increased?' And Jorm again, 'Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries.' And again, the answer is no. Now, some commentator argue that the lack of improvement in mental health is due to inadequate or a non-evidence based treatment, and that the solution is more and better treatment.

However, I have, and I'm not the only one - it is more likely that the lack of action to address social determinants of mental health is the key issue.

**MS ABRAMSON:** Dr Raven, I'm sorry to interrupt you. We do have some time pressures on us.

**DR RAVEN:** Okay.

**MS ABRAMSON:** And so perhaps if you could, assuming you've put in a submission, or a lot of the references that you've referred to are in written material that you've provided to the Commission. So if you could perhaps address the things that, in the last - in five minutes, the things that are really pressing for you.

**PROF KING:** That being said, I'm about to ask a question. So, in the literature, and we're aware of - well, I've actually read some of that literature, but not all of it. So at a population prevalence level, there's no evidence. For example, you don't see better access in the population level (indistinct) evidence, and that's Jorm, one of Jorm's favourites. And on your basis of the social determinants of health, you wouldn't, unless you addressed those issues such as housing, poverty, and so on, you're not going to see that.

But do you see - is there work that's being done on - do you see a reduction in the intensity of mental health issues? So there's a prevalence issue versus an intensity issue.

**DR RAVEN:** No. I can't say off the top of my head, but I know some of these Chinese studies have looked at - - -

**PROF KING:** Intensity.

**DR RAVEN:** - - - criteria such as, you know, scores on the (indistinct).

**PROF KING:** Yes, okay.

**DR RAVEN:** Or something like that. So it's not just the numbers of people that have achieved it, it's also a - you know, it's the overall burden of mental disorders. There's just not - - -

**PROF KING:** Okay. No. So that's a good point. Sorry, and just your third one was?

**DR RAVEN:** My third one, very briefly, is what many economic analyses, including several economic analyses that have been cited in the draft report, and some of the actual analyses in the draft report include problematic, non-evidenced based assumptions, and I'll just very quickly mention two - two examples in the Commission's modelling that I think are problematic, and I'm looking at - in Appendix F.

**PROF KING:** Yes.

**DR RAVEN:** At table F3. Firstly, in relation to change - - -

**MS ABRAMSON:** Our modellers will be very happy that someone's read Appendix F.

**PROF KING:** Other than me.

**MS ABRAMSON:** Other than Stephen.

**DR RAVEN:** I'll tell you, I went right through Appendix G, because somewhere in the report it says Appendix G, and I finally found out that it was meant to be Appendix F.

**PROF KING:** Sorry, Appendix F and the assumptions that are - - -

**DR RAVEN:** Yes. In relation to changes in workers' compensation for mental health claims, no reference is cited for the assumption time on workers' compensation will be halved. Now that's a pretty bold claim, but no reference is cited. Most of the items in that table do have references cited, and there's not any reference cited on pp.76-78 of the draft report where it's discussed.

**PROF KING:** Time on workers' compo.

**DR RAVEN:** And I will just quickly draw the Commission's attention to a Canadian study by Ebrahim et al, 'Association of psychotherapy with disability benefit claim closure among patients disabled due to depression', which found, paradoxically, receipt of psychotherapy was independently associated with longer claim - longer time to short-term disability claim closure, and faster long-term disability claim closure in patients with depression. So sometimes there are paradoxical effects.

And secondly, in relation to improved social and emotional learning in early childhood and school education, I think the projection to adult employment outcomes is extremely problematic, and I just point out the cited reference, (indistinct) et al 2012 actually cautioned given that more than half of the studies reported only post-test data collected less than half a year after the end of the intervention, conclusions about the lasting effects of these programs need to be made very cautiously. So I really do not think that's the (indistinct) supports the claim that it is cited to support.

And my final comment on economic analyses is that actually these sorts of problems are extremely common in the - in the mental health economics field.

**PROF KING:** Yes.

**DR RAVEN:** And that's (indistinct).

**MS ABRAMSON:** Thank you.

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

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

**PROF KING:** I think I know where we did the workers' compo half lines, because there's - well, I can't be sure there's actually natural experiments, because some states have already done the intervention that we were suggesting, and some states haven't.

**DR RAVEN:** Can you please tell me that in the final report there's going to be a detailed - you know, there's going to be tables whatever it is on steroids, with lots of references cited to lots of (indistinct).

**PROF KING:** Hopefully so. I know the guys are working on it as we speak. Thank you very much. Caroline Johnson next. My co-Commissioner is going to get out the - - -

**MS ABRAMSON:** The co-Commissioner is a lawyer by training, and therefore there's process.

**PROF KING:** I can see the thumb screws are getting out on me regarding the timings and so on, so if you could please introduce yourself, any organisation you're representing.

**DR JOHNSON:** So my name's Caroline Johnson. I'm representing the RACGP, Royal Australian College of General Practitioners, not to be confused with (indistinct) who was representing general practice and mental health standards collaboration.

**MS ABRAMSON:** Yes.

**DR JOHNSON:** Although we obviously have some overlap. So we're a very big college, the largest professional medical practice for colleagues representing 42,000 members. Our members provide over 158 million services to about 22 million Australians every year. So there's a lot of activity in the mental health space. So I was really pleased to come and talk and, like Jeff said, I assume you've had a chance to read our submission. I'm sorry, but I guess I'm prepared to sort of pick which one you'd like to ask questions, or like me to talk to.

I mean, obviously the response we wrote was very much sort of in defence of the concept of mental health plans, and maybe a little bit in defence of the concept of better access, but with an acknowledgement that both these initiatives are well overdue for a bit of redesign and a rethink to address some of the concerns, rather than just sort of getting rid of them altogether, and then also, of course, the issues around funding of general practice, which again can sound like doctors are talking about being paid better, but I think it's much more about, you know, equitable reward for doing mental health work compared to the rewards doctors receive doing physical health work.

Because otherwise the profession - and I train GPs, and I've been doing that for 20 years. The interest in doing work that is poorly remunerated and very emotionally demanding and difficult gets less and less, without some rewards, and I don't think they should just be financial, but I do think we have to acknowledge that mental health consumers deserve access to the same quality care and the same dedicated professionals as people who need physical health care, which comes back to that issue, you know, if we tried to a

Productivity Commission on the whole of physical health, we wouldn't be talking about everyone altogether.

**PROF KING:** No, that's right.

**MS ABRAMSON:** I think you might kill the Commissioners if we had to do it on the whole of the physical health (indistinct).

**DR JOHNSON:** But here we are today with this struggle about - I mean, you know, high prevalence and - or low prevalence disorders, and the reality is, in general practice we see all these things. We also see the missing (indistinct) or they're not missing to us, and so I guess, just to frame that conversation, and I don't want to really neglect either side of - or breadth of what mental health wellbeing is, because we're also interested in early intervention and prevention. We're also interested in the fact that, as the previous speaker said, a lot of the interventions don't actually work.

We would probably believe that there's still reason though for hope, and that if an intervention doesn't work, the main thing is that people stay engaged in care, and I think general practice plays a really important in keeping people engaged in care and keeping them - to have hope even when some of the interventions we're trying aren't immediately effective, and there's a lot of complex reasons around that. So I don't know where you want to go with the short time you have with me, what things would be most useful to you.

**PROF KING:** Mental health, as we mentioned at the beginning, mental health plan and better access would be the two that I'd want to focus on. Yes.

**MS ABRAMSON:** Also, and I just had one, if I could, Stephen.

**PROF KING:** All right. You go first.

**MS ABRAMSON:** We've heard a lot today, and yesterday when we spoke to consumer groups about the importance of lived experience, and at the Commission, we're really thinking hard about how we make a meaningful thing. It's not a tokenistic, well, you consult over here. Because you've got a lot of experience in working in the area, I'm interested in your experience where you've seen it work well, and it's a co-design, co-production.

**DR JOHNSON:** Well, I hope this isn't controversial to my consumer colleagues to say it, but I think most of the best co-design happens actually in my consulting room, which is where you have a relationship-centred approach, and you say to the person that needs help, well, what do you want? So for many, a mental health treatment plan is so important, because I say, there's a bit on the form that we're meant to write what your goals are. But what are they?

**MS ABRAMSON:** Yes.

**DR JOHNSON:** And let's not do the plan today, because you're not quite ready to declare what you think you want to achieve. So I think, you know, we have to remember that it does happen every day in the privacy of a clinic or a consulting room, or anything else. At a broader level, I think, certainly the GP land, we were probably one of the first organisation, I believe in the world, when 20 years ago we agreed with consumers and carers that if we were going to set the standards for mental health training for GPs, we definitely needed both people with lived experienced, carers as well around the table, and to this day they are contributing.

I think more could be done in that space, and I think it's really exciting to hear about models like co-design and collective impact, and I do think that the more consumers have leadership in that, the more bang we'll for that. I think, unfortunately often clinicians find that scary, because the true believers kind of go, well, we know what you're saying, but we're also a burnt out like system.

**MS ABRAMSON:** Yes.

**DR JOHNSON:** And I think that's a shame, but I don't think that's a reason not to keep trying. Yes, so I'm all for it, I guess, basically, and I think you learn - I mean, I spent a lot of time teaching my young doctors, you'll learn more by listening to and being effective and honest with the people who are coming to you for care than just following guidelines. And again, I think GPs are really good at that. So we grapple all the time with this issue of, you know, you have to have a diagnosis to get into service.

GPs are very good at being pragmatic about those kind of things. When is it safe to label? When is it not safe to label? Does it mean you get a service? Does it mean you disadvantage a consumer? That kind of stuff, that's kind of bread and butter for GPs and working in that level of uncertainty. Young doctors who come to general practice are often quite shocked, because they come from the hospital and they take a big pay cut, and then they find they have to deal with what are (indistinct) and really complex tasks.

And of course, what happens to them is they say, gee, maybe I'd rather just do a bit of skin cancer medicine, or a bit of cosmetic medicine, because this work is really, really, hard. So certainly, I've made my career and goal to say, well yes, it's hard, but it's really important. Because I do think, while I agree you can't necessarily say that population level - we can be sure this makes a difference, I think that it's a non-brainer, that it's really important because of the prevalence and the rate of mental distress that we should be doing things in a primary care setting.

**MS ABRAMSON:** Thank you.

**DR JOHNSON:** I think I've gone off a bit.

**MS ABRAMSON:** No, no, no, it was helpful. Thank you.



**DR JOHNSON:** So turning to better access, I guess - I mean, I'm really lucky because I started my mental health and advocacy career in the late 1990s. I was a GP educator and we were running courses for GPs, and we started looking at the literature, and at that time, a lot of people were saying, GPs are missing mental illness. We just need to train them. So we did that. We trained them. Then the opportunity to set up Better Outcomes came along at about the same time as in the US Wagner was describing his chronic disease model of care, which said, you know what, honing clinicians isn't enough. You also have to (indistinct) people or find the cases of people, because people won't necessarily come.

And guess what? Even that's not enough. You actually have to offer them an intervention that probably works, but even that's not enough, because it won't work all the time. You actually have to give people self-management skills and you have to make sure they come back and keep coming back for care until you actually get an outcome. And it was a really fantastic concept, and two colleagues in Washington Uni, (indistinct) and Elizabeth Williams, a psychiatrist and a GP, said let's actually implement this because we want to see that we don't actually believe that the problem is we're not finding people with mental health problems.

The problem is we're offering them treatment, but we're not actually doing enough. If I could do that a bit better, it's not enough, and actually treating the people who already have a problem is probably more important. So that's when these collaborative care models for depression emerged, and really, Better Outcomes was really designed on that. You know, you might remember, it said we'll give you a financial reward if you actually bring the person back and actually make sure that the intervention you offered got them better.

But for various sort of policy issues and MBS funding implications, it got changed to Better Access. Now Better Access was good, because it meant you didn't have to have training to actually refer people, which addressed the problem of the reluctant GP, the one who wasn't being trained, but it also actually really got GPs doing more training. So now we can say 85 to 90 per cent of GPs have to the training. So the training that we all agreed, and it was multidisciplinary, (indistinct) carers, psychologists, GPs, policy makers, we all agreed, this is the kind of training we want GPs to have, and 90 per cent of GPs have the training, but still we get anecdotes that they're not all doing their job.

I personally think that there's lots of other reasons other than training why we mightn't always get the quality we're looking for, and I think that's the area where we could probably do the most (indistinct) and I don't want the message to come out that we don't think we should train GPs. Of course we can always improve our training.

**PROF KING:** Yes.

**DR JOHNSON:** And I've spent a lot of my career trying to do that, but I think you can't really train someone and then put them into an environment where they can't exercise their training - - -

**MS ABRAMSON:** Yes.

**DR JOHNSON:** - - - because the system works against them, and the biggest issue there, of course is, the fee for service model that encourages short consultations, and that's why the college chose to clarify that in their second submission which is whether to look at the financial rewards for doing mental health treatment plans relative to the income you can generate with the assistance, for example, of practice nurses.

**PROF KING:** Yes.

**DR JOHNSON:** You know, it's actually an economic death for general practice if you - if you said, like I do, 'I'm going to do 50 per cent of my practice doing mental health work', I actually generate about 25 per cent of the income of my colleagues who are doing - now, I choose to do that, but that's not a solution for the whole profession. If you're really saying that everyone's going to general practice, you need to make a system where mental health care gets the same reward as you get for doing physical health care, and I think some of the recommendations we've made are around that.

When it comes to the mental health treatment plan, I actually did my thesis on looking at, well, I got interested in these outcome measures of monitoring and if one case is right, well, how do you actually know that someone's getting better, and I did some case studies and talked to GPs considering without carers, and what I realised for most conversations is that the mental health treatment plan is really a key tool for engagement in the process, particularly for the GP.

I don't think it's necessarily shared with psychologists. In fact, some psychologists I use actually say on their website, 'We just need a referral. We don't need to see the mental health treatment plan'. I would argue that's possibly a failure on our part to get into professional practice happening, but I think it's also acknowledging that maybe for the psychologist the plan doesn't matter, but a plan done properly for the consumer and the carer.

And the GP is really important because it doesn't just cover what's your diagnosis. It covers, what are your goals, what have you done before? If it didn't work, what are you going to do differently? It also covers what kind of therapy is the best therapy for the kind of problem you have, and everyone is alluding to, it's not always CBT. It's not always even a small list of psychological interventions. So a plan should be able to introduce other things like physical health care, like psychosocial things but the mental (indistinct) hasn't fully realised that because it's been overly focussed on referral from a GP just like - - -

**PROF KING:** Okay. So can I jump in there.

**DR JOHNSON:** Yes.

**PROF KING:** So one way would be to try and transform the mental health care plan.

**DR JOHNSON:** Yes.

**PROF KING:** And the GP's role so that it included things like psychosocial support.

**DR JOHNSON:** Yes. Yes.

**PROF KING:** The alternative is to say, like it or not, we have the current fee for service model for GPs.

**DR JOHNSON:** Yes.

**PROF KING:** We know there are a range of GPs, some who are very interested in mental health, but others who are saying, 'Look', as you said, 'because it's death to my practice if I spend more time doing this. I'm more - I've got my full book with short and a number of long consultations during the day and that's how I want to run my practice'.

**DR JOHNSON:** Yes.

**PROF KING:** So is it better to actually say, and I asked a similar question earlier on today, to have an, external to the GP, triage process, along the lines of what they've got in WA, where the GP can say, okay, there's a mental health issue here. I'm going to refer you on to this. I don't need to do the mental health care plan.

**DR JOHNSON:** Yes.

**MS ABRAMSON:** So they can - - -

**PROF KING:** They then contact the individual and there is much more time and space to triage, much more ability not just to send them down a clinical path, but also the psychosocial form.

**DR JOHNSON:** Yes, so that is already happening. So certainly the PHN in my area already offers a, you know, front door approach, no wrong door. I also sit on a group that's looking at developments in national standards for this assessment and referral process and it's been really interesting to think about what the PHNs are offering in that space and my concern is, a lot of them are actually offering a non-clinical triage, so someone turns up, even if the GP writes a letter saying, 'This person's got a problem. Fix it', and someone with no clinical training asking the person a few questions over half an hour without thinking about the more holistic approach.

Now, I would argue, if GPs aren't doing that, let's fix the GPs who are; let's look at the reasons why they're not; but still may have no problem with having that as a backup for when GP services fail, and there are a lot of reasons why GP services fail that have nothing to do with GPs, which we could talk about later.

So I think that's good as a safeguard, but I don't think it's the model we should aspire to because we know that people, especially with serious mental illness, also have quite complex physical health care needs, and if you do something that says, 'Let's carve out' - I mean, Americans use this language, carving out behavioural care from physical health care. Let's just make it a separate thing and cut the body in half. There's your mind and there's your body.

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

**DR JOHNSON:** And I don't think that's a good principle. In fact, WONCA is a welfare organisation produced a document a few years ago looking at countries all around the world with much poorer health systems than Australia, and when they integrate mental health care into primary care it reduces stigma, it reduces discrimination. It makes care more accessible. It ensures that physical and mental health care get addressed together. So we would prefer that those models are better integrated into primary care, but with an understanding that that won't work in all situations, and clearly there are some areas, but I think we're failing to look at the reasons why it's not working in some areas, and that I think is more important.

**PROF KING:** Okay. Can I - I want to push back on that a bit because I know that it's - you're creating separation, but if I go in and my PSA is high, then the doctor will refer me off down a particular - to a urologist, I think, to a specialist and then that specialist then, you know, keeps my doctor in the loop and I may have, you know, a sore hand at the same time, and so my GP is in a sense managing a whole range of referrals. Why is it that if you say the GP is also then referring off to the mental health service, why does that create a difference or a gap?

**DR JOHNSON:** Well, that's a different - that's a slightly different question than the one you asked before which was, will the GP just flick a person off without assessing them. So a person that I refer to a physical health specialist, - - -

**PROF KING:** There still has to be an assessment obviously.

**DR JOHNSON:** - - - still gets an assessment from me. So for example, the chap who comes in saying, 'I want my PSA checked', my job as a GP is, as a steward of very expensive health services is to say, 'Well, do you really need a PSA? What's your risk? Is it an appropriate screening test? What do the guidelines say', and PSA is a particularly complicated example.

**PROF KING:** Yes.

**DR JOHNSON:** Because the evidence for referring someone off for a testing is contested.

**PROF KING:** Yes.

**DR JOHNSON:** But that's the GP's job, and also to say, 'Well, hang on a minute, while you're also here for your PSA, did you know that actually you're much more at risk of dying because of your family history of, well, this or that'.

**PROF KING:** Yes.

**DR JOHNSON:** That holistic approach is what GPs are trained to do.

**PROF KING:** Yes.

**DR JOHNSON:** And so if you said to someone, 'Off you go somewhere else', then the GP might not do that. What you're really asking is, could a GP do a referral without a mental health treatment plan.

**PROF KING:** Yes.

**DR JOHNSON:** And the answer is clearly yes, there would be some GPs who would say that's a fantastic thing because it would save me a lot of time and save me a lot of money, and I think the services we now have already address that issue, but I don't think it's best practice. I would prefer that my colleagues say that if someone has a mental health problem they deserve the same kind of assessment as you would offer someone with a physical health problem.

So if someone comes in with high blood pressure or breathlessness, they need a cardiovascular exam and a respiratory exam.

**PROF KING:** Yes.

**DR JOHNSON:** If someone comes in and says, 'I'm really, really sad or really worried', then I think they deserve the holistic primary care assessment as well. GPs are trained to do it. I don't see why you would want to carve it off for the majority. I think, and this is one of the problems we are losing in our Australian health care system, is this notion of generalism, but there's lots of evidence about the more strong generalist workforce you have, the better you are able to provide services.

Paradoxically maybe, because you're actually using people who theoretically know less complex stuff, but it's the ability to apply all this complexity at a grass roots level means that we can address the care for people in rural, urban settings and people with a lot of diverse needs, and that's something that I think only people working in general practice really understand fully, but there is research to support that model.

But I hear what you're saying. I think there are GPs who would say, 'I'd rather not do that'. My job with young doctors is to say, 'Actually, then, are you really a generalist because if you want to be a skin cancer doctor, then be a skin cancer doctor'. We need to bring more people to this notion that we need doctors who are trained to lead teams, and

this is the other point that, if you're going to say that we want generalists who can lead health care teams, then you need to make sure you have mechanisms where the team actually function, but at the moment we don't have that. We've already seen the report you mentioned. Case conferencing doesn't really work.

**MS ABRAMSON:** Yes. Yes.

**DR JOHNSON:** Telephone consultations don't really work. Unless a person is sitting in a room actually seeing the doctor, it doesn't work.

**MS ABRAMSON:** Yes.

**DR JOHNSON:** The only way we can pay our practice nurses is because we generate income for doing all these plans so that we can pay the nurse's salary. We used to be able to use the nurses for wound care and immunisation, but now, unless I walk in the room and say, 'Hello, Beth. The nurse is just going to give you an injection', we don't get an income for that service. These kind of stupid policy things that don't actually foster team work.

**PROF KING:** Yes.

**DR JOHNSON:** So, and that's why the college has done all that work on we need a, you know, patient-centred medical home because it's saying, of course it's not just the GP.

**PROF KING:** Yes.

**DR JOHNSON:** But it needs to be in the community in that environment, and there's some really exciting things happening in general practice now. Everyone's gotten a bit sick of waiting for the government to solve the problem, so you do see clinics self-organising now, often larger clinics, which is a threat, of course, to smaller clinics. It's a threat to community for rural-based settings. Recently one of these larger clinics in a rural setting had serious financial problems. There's a lot of threats because the small business model is challenged.

**PROF KING:** Yes.

**DR JOHNSON:** But I would argue they're the kind of things that need to be addressed, rather than saying, well, some GPs aren't doing the right thing. Therefore let's just, you know, forego that process.

**MS ABRAMSON:** In fact, it's a general push because the private health insurers are making strong representations - - -

**DR JOHNSON:** Yes.

**MS ABRAMSON:** - - - to be able to do much more in mental health in the community.

**DR JOHNSON:** Absolutely. Yes.

**PROF KING:** All right. Thank you so much.

**DR JOHNSON:** Okay. Thanks very much for having me.

**MS ABRAMSON:** Thank you.

**PROF KING:** And Michael Innes I think is next. Michael, if you'd be able to introduce yourself, state your name and any organisation that you represent for the transcript and then any comments you might have.

**PROF INNES:** Thank you. Thank you for the opportunity to make a submission. I make the submission as an individual.

**PROF KING:** Yes.

**PROF INNES:** And so I have been associated with many psychological institutions across the years. These views are my own as a result of my analyses of the literature and the practice of psychological science and they should not be attributed to any institution with which I have been associated.

I have to declare that I am not a clinical psychologist, a registered psychologist and should not be referred to as a psychologist. To do otherwise is to risk my being fined substantially by the Australian Health Practitioner Regulation Agency. I call myself a behavioural scientist with extensive training and experience in psychological methods.

My comments pertain to models that affect the workforce and I declare my awareness of the submission that we made to the commission by the Australian Psychological Society, and their recommendations to the Commission made at pages 13 to 16 of their submission.

My concerns are that there were no references made in the draft report of the Commission, or in the submission by the APS that the possible and timely impact of the government's automation and artificial intelligence affecting professional education and employment.

Access to health services related to mental health continues to emerge as a crucial factor, but the absence of the likely impact of artificial intelligence, I think, overlooks a major future opportunity for treatment and also is a threat to the workforce and the community.

The discipline professional psychology currently provides services to assess clients' state of wellbeing in mental health to enable a formulation or diagnosis of any condition which can undermine a person's capability to function; to design and implement an intervention

to treat the identified condition and evaluate the positive and negative outcomes of that intervention.

These four components, assessment formulation, intervention and evaluation are the pillars of psychological treatment. These components are all capable of being significantly augmented and/or replaced by machine intelligence. AI presents a threat to the employment of skilled and professional people across the spectrum of occupations.

The development of AI has been proposed, however, not to have a likely effect upon sections of the workforce such as psychologists because of a requirement that such people to have skills, the so-called soft skills, including empathy, which cannot be provided or emulated by machines. We believe this assumption to be false. Psychological treatments can be provided by machine and will be more reliable and valid.

The use of AI can be shown to elevate the reliability and validity of all processes within the four components I have enumerated. Machines can access information regarding the efficacy of measurement, interventions and evaluations faster, more reliably and with stronger differentiation of validity than can human operators, and I'm dealing here with a narrow definition of artificial intelligence. This is based upon presently available machine learning systems. These interventions can be replaced.

We're not talking about Skynet going self-aware in August 1997. We're talking about narrow definitions of AI. If general AI systems emerge, then there is the prospect of very widespread replacement of human psychologists, but the threat of already available narrow band systems are imminent and real.

So attention needs to be paid to both the impact generally of AI development on the employment of large sections of community which is outside the remit of this investigation, with implications for the mental health of the general population and also to the provision of services to the population through machine intelligence. That will however, if that occurs, and is occurring, there will be possible severe impact on the employment prospects and the training and education of psychologists in the workforce.

One can argue that the even if there is a general overtaking of provision of the workforce by machines, there will continue to be a need for highly experienced experts to influence and monitor the development of automated services, but as AI systems evolve and intrude into higher and higher levels of delivery, the opportunity for psychologists to gain experience and thus expertise will be reduced and a cohort of experts will be shrunk in a circular fashion.

We need also to be cognisant of the evidence, the strong evidence, that experience per se is not a good predictor of success as a psychologist. There are wide individual differences in capacity and narrow AI systems will be able to replace in an ascending manner the capabilities of increasing numbers of trained psychologists. These concerns have expanded in a number of recent references which I can give you access to.



I also point to the work of the economics Nobel warrior, Joseph Stiglitz, on the implications of poor - of unemployment of artificial intelligence, and a clear, comprehensive and (indistinct) review of the issues associated with developments in artificial intelligence can be found in the Australian Council of Learned Academies report authored by Professor Toby Walsh and released in late 2019. That's my statement. Thank you.

**PROF KING:** Thank you. So, and I won't pretend to be up-to-date on the cutting edge of AI and where we're sitting at the moment. My understanding is, certainly research up until a couple of years ago is that while AI and machine learning from large data can be used to replace parts of jobs, so you have things like the KPMG, I think it was, report from the UK which always gets quoted, and as far as I can tell that makes the mistake of confusing loss of jobs with loss of parts of jobs.

And certainly up until a few years ago the best evidence from AI research was, yes, machines and 'intelligent', and I'll do the finger quote, sorry for the transcript, because it's not really intelligence, but they are able to - well, they are best - the best outcomes occur when you have the humans and machines working together, not the machines replacing the individuals, which shouldn't surprise us because we have more than 250 years of industrialisation where it's very rare for the machines to replace the humans, rather the machines and the humans work together and there's an increase in productivity and that's been the main cause of economic growth for the last 250 years.

Why shouldn't we be taking everything that you've said and said, 'This is brilliant. Psychologists will be so much more effective'. Will there be less demand for psychologists? Well, we don't see that in other areas where there's a massive increase in productivity. In fact, it means that the current waiting lists and shortages that we've referred to in the mental health system will hopefully be massively diminished, and we'll end up with a great win for the consumers who are the ones we care about. So what's wrong with my picture?

**PROF INNES:** On the face of it there is nothing, absolutely nothing wrong with your picture. I think however, and we believe, however, from our analysis of the the work practices of psychologists is that they are in fact not able to provide things which cannot be done by machines.

They can be replicated by machines, and therefore there will be an opportunity for the machines to be operating and therefore replacing psychologists, not just augmenting them. I think there had been a sea change in the way which machines, which are predicated upon learning, the algorithms which learn from first principles, can't, in a very short period of time, replace the functions that they had thought to be able to be simulating on mimicking, and therefore I think in the next 10 years we have to look to a very, very significant change in the world we have for how artificial intelligence will have an impact upon employment, especially in the professions, and you can always look to the past.

It was, I think, on the radio this morning about we've replaced agricultural workers with industrial workers, and, therefore, there will be another phase of creative workers who replace the industrial workers, but the evidence for the artificial intelligence literature now is once we move from an idea that you could simulate how humans think to a machine which puts into place a different system of thinking, then we have changed the whole part of that, and that's the problem that I see and we see emerging in the employment of psychology. It's a good – sorry, Commissioner. It may be a good thing in that it's going to replace a lot of treatment of mental illness, but it will be at the expense of psychologists and not simply at the augmentation of psychologists.

**MS ABRAMSON:** We've seen it in financial services, like artificial intelligence in terms of financial plans and things like that, but, I mean, correct me if I'm wrong because I may have misunderstood, but that runs to algorithms that are quite good at predicting the type of financial products that someone might want or might need, but people are so – I mean, I feel embarrassed talking to a room of psychologists, et cetera. But people are very complex, so how is it that you would be able to have the machine learning that would be able to replicate the things that a psychologist might do?

**PROF INNES:** Well, if I can explain the reason I got into this particular realm of thought was because I saw some of the data which came out from Oxford and from KPMG and all those kind of worlds that said quite simply that there is a threat to general employment, but it's all right, psychologists have got a .005 per cent chance of being replaced by mods. But when you go into their algorithms they assume certain things that psychologists do that can only be done by empathic psychologists, but an awful lot of things that psychologists do are reviewing the literature, looking at the evidence base.

I heard previous speakers talk about the evidence base and all the things that are available. Machines can access that literature far more efficiently than any of us in this room can do. Machines can carry out the assessment and the diagnosis of conditions more reliably. We've known for 60 years that algorithms are better at diagnosis and assessment than human psychologists. These processes are being replaced and are replaceable by the machines, and so there's going – I listed four pillars: assessment, formulation, intervention and evaluation, and at least assessment and intervention and evaluation can all be done by machines more reliably than a psychologist.

**MS ABRAMSON:** But, you know, it could be a thing that's positive too because one of the things the Commission has been struggling with is getting services to people in rural and regional Australia. So leaving aside the quite complex and difficult issues, we can't get some people to use services online. I mean, that's the first challenge for the Commission. But it could actually be something as it develops that's a really good way of getting services to people.

**PROF INNES:** Undoubtedly. But if services are produced for rural and regional Australia and can be shown to be superior to what has been done, then bracket creep will be introduced to people who are living in other areas of urban Australia because it will be deliverable. And a lot of people do prefer interacting with machines rather than with

humans who tend very often to evaluate you and raise their eyebrows when you say certain things. I mean, machines can be more abstract, can be more impersonal, and that is an advantage (indistinct)

**PROF KING:** More anonymous.

**PROF INNES:** Sorry?

**PROF KING:** And more anonymous (indistinct).

**MS ABRAMSON:** I'm terrible. I keep thinking of the computer in 2001, HAL. Do you know what I mean?

**PROF KING:** HAL, yes.

**MS ABRAMSON:** Yes.

**PROF KING:** You can't do that.

**MS ABRAMSON:** You can't do that, yes.

**PROF INNES:** (indistinct) but it's – yes. And those are the models that we have in our head about how machines can do what they can do, and your point is taken, Commissioner. There will be an advantage for services and resources in the next few years, but if we do not really formulate this and face up to it, then the workforce will be hit by a tsunami of change when we're not prepared for it, and we think we need to be factoring into projections for the workforce and for the treatment of people from that workforce with the possibility that there's going to be a change in the way in which we train psychologists, employ psychologists and have a view to the nature of the workforce's cycle.

**MS ABRAMSON:** Look, it's a really interesting submission. To be frank, it's not something that we would have turned our minds to, but, given that we see so much change in other professions, there's no reason to think that there wouldn't be change in psychology.

**PROF KING:** No. But I would say as somebody who's a techno-optimist and I was massively out on my predictions of self-driving cars and I'm not (indistinct).

**MS ABRAMSON:** You and everyone else, I think.

**PROF KING:** Yes. But the problems have just been much harder because, damn, humans are unpredictable.

**PROF INNES:** And I think - - -

**PROF KING:** So I think your main point is - - -

**MS ABRAMSON:** I think it's very interesting.

**PROF KING:** - - - that there's a change, and the profession has to be aware of the change in the chain, but I think we've got time.

**PROF INNES:** Yes, we have time, but it's a shrinking window.

**PROF KING:** I understand.

**PROF INNES:** And I think the legal profession is finding the same kind of pressures in the ways in which a lot of the work is done by lawyers is being overtaken by machine learning.

**MS ABRAMSON:** A huge amount. Probably at the risk of too much information for this inquiry, as a junior lawyer we were forced to go through all the documents for discovery, and now machines are doing it. Yes, absolutely.

**PROF KING:** And you've just stolen my end joke where I was going to put out that the psychologists would be out of work and they would join all the lawyers. So thank you very much.

**MS ABRAMSON:** The lawyers find other things to do. Thank you.

**PROF KING:** Fortunately, economists are completely unpredictable and relatively random which machine learning will never be able to – I'm not sure I should say things like that. But next person, Karl - - -

**MS ABRAMSON:** Well, I don't know. Paul Rose has got you on the transcript.

**PROF KING:** It's on the transcript too. Karl Brettig, please.

**MR BRETTIG:** Yes. The psychologists would be having to deal with the same issue as the print media. They thought they had plenty of time too, but journalists now are in disarray.

**PROF KING:** Print media has been extraordinarily slow to adapt, and my take on print media is that – sorry. You're getting me on to a hobby horse.

**MR BRETTIG:** You've got to remember - - -

**MS ABRAMSON:** And you will be getting off the schedule for the time. I will have the whip out again.

**PROF KING:** Sorry. Before joining the PC I was an academic. The area of economics that I worked on was competition economics and mainly areas like digital platforms and so on, so, unfortunately, you've got me on my hobby horse. Please state your name, affiliation, who you're representing and any opening comments, and I will be quiet.

**MR BRETTIG:** Yes. My name is Karl Brettig. I'm the manager of Salisbury Communities for Children which is based at the Salvation Army at Ingle Farm. You have a submission from the Salvation Army.

**MS ABRAMSON:** Yes.

**MR BRETTIG:** Which covers employment and homelessness and children, but I will be speaking to the children aspect of that.

**MS ABRAMSON:** And I understand, Mr Brettig, that you wanted – as a supplementary to your submission you had a video presentation which you're able to send through to us.

**MR BRETTIG:** Yes. That was in the context of 15 years of Communities for Children people still don't really understand what it is, and so we developed a video which actually explains it, but probably before I will have to explain something about it because probably not too many of you are very familiar with - - -

**PROF KING:** Just briefly. Sorry.

**MR BRETTIG:** Well, it's funded by the Department of Social Services. It started about 15 years ago, and there are 52 sites throughout Australia, and each site is a cluster of suburbs, and in each of those sites there are areas where there are low socioeconomic conditions, and the model operates through designating a facilitating partner in each area to bring together services to support families, initially with 0 to 5, and then 0 to 12 children. So, that was established in 2005. I noticed in the draft report, I think on page 656, it talks about getting families support around children in the early years, and it says that the services are largely fragmented, and not coordinated and are often not getting to the people who most need them, which is a good observation.

And I guess, to put it simply, communities of children is a model which the Federal Government put forward to try and deal with that issue, and bring together a structure which will enable people to come together as a representative group from the community, and work out a strategic plan to address the issues within a community. So that's going to be different in each community, but that model has been in existence now for 15 years, and now we're seeing collective impact, I guess, as the model that's being looked at, but there are lots of parallels between what the community children model has been doing for 15 years, and there are lots of learnings that we've had in that time, so it's been a fantastic opportunity to look at how we can actually work together better in local areas.

So, it's really an early intervention and prevention model approach. So in some ways it's outside of the scope (indistinct) Commission. As we talked about earlier, with the social

(indistinct) of health not being included as part of what we're about, but we live in a complex system, and it's probably good to talk a little bit about what we can do in terms of early intervention and prevention in the mental health area. In our experience, we discovered that there are probably two windows of opportunity that you get, and the economics of it are such that, you know, well (indistinct) talks about a ten-fold return on investment in the first 1,000 days, the early years. We talk about the first 1,000 days.

So if we can put as much support around families in the first thousand days, as we can, we will get a really significant return on investment, in terms of what we will save down the track in terms of mental health issues, drug and alcohol issues, homelessness issues and all of the other cast of issues that we get. The other opportunity is through junior primary school, which is the second window of opportunity, which probably doesn't bring the same amount of return on investment as investing in the first 1,000 days but it is significant, and so I will try to talk to both of those in a bit, and we can talk. I'd be really keen to hear your questions.

What we've done, we found that in terms of wrapping support families in the early years, post-natal depression screening initiative with the government is already good, and we found initially we got a lot of referrals from that. And when we did our consultation with the community, we found that people were really looking for a one-stop shop. They were looking for a place where they could go and not have to be referred from one place to another, but they could get significant number of services and supports in the single space. In South Australia, we have (indistinct), I think, in residence who was talking a lot about how we could do that, and in South Australia and a number of other states, children's centres have been established, children's centres for parenting and early childhood support.

And so, in our context, at Ingle Farm, we found a space in a school, and – which was the equivalent of about 10 class rooms – and we set up a space where families could come, and then get support. And we, in the process, through our committee, we brought together a government, non-government, education, health services, and we sat them around a table and we worked out how we could create, really, a community of support around families and children who were at risk of adverse social outcomes.

And the primary issue, I suppose, that we've discovered, is – is really critical in terms of early intervention, prevention, is really the issue of attachment. So, post-natal depression screening identified a lot of people who were at risk of having poor attachment issues, and there are numbers of initiatives developed around that, we developed one called Being with Baby, which provides support for mums, particularly, and so it's – within the context of a family setting, where the babies can be looked after, while the mum's are able to be free to engage in group process for about 10 weeks, and we have a (indistinct) redeveloped. So they often get the kind of psychosocial supports that they really need, and build healthy attachment. And then following on from that, we can then link families into – there's a parenting course called Circle of Security, which builds attachment, and we've developed other parenting courses then following on from that, once we (indistinct) together.

So, in a crisis, people – we have found, for example, people will come to the school and maybe have had a domestic violence event over the weekend, and they'll come to the school, and the principal will then be able to take them into the family centre, and say – you know, schools just do not have the capacity to respond in the (indistinct) kind of a way, to that sort of situation. But within the context of the family centre, or a children's centre – or a child and family centre, sometimes they're called – there are differences between them, but there are also parallels. So they can get wraparound services and support, and they can be linked in to other supports. It really is developing a village around the child, community around the child is the concept.

And having the option to do that has been fantastic, and we've been able to measure it in terms of population health outcomes, in terms of the AEDC we saw a - Australian Early Development Census – we saw a reduction in vulnerability of 10.4 per cent between 2009 and 2012. We started in 2006, so that (indistinct) would have been picked up by the AEDC in 2012. It obviously wouldn't have been picked up in 2009, but we saw – yes, about 10 per cent improvement in vulnerability. And we can say with some confidence that that related to the Communities for Children project, because we had – we were part of a national evaluation, and we had baseline data when we started, so we knew which services were added during that period. And when that cohort got to, in 2015, the NAPLAN, again there was a really significant improvement at Ingle Farm in terms of the literacy and numeracy outcomes for those students. And also, we saw a reduction and substantial (indistinct) of child abuse in the area.

The other concept is the world being a classroom. We initially were working with children 0 to 5, and then we go to work with children 5 to 12, as well. And so we got to – and of course, those children are in schools. We looked at what was actually happening in terms of social/emotional learning, within the context of schools, and we found that there were already a lot of social learning programs starting out, starting to be part of the school curriculum, but we found there wasn't a lot in terms of emotional learning, so we looked around and we discovered a program called Kimochis, which is basically built around teaching children to identify feelings, and have a feeling vocabulary.

**MS ABRAMSON:** Sorry, what was the name of that program?

**MR BRETTIG:** Kimochis. It was developed in – it's a Japanese word, but it's developed in America by a person called Ellen Pritchard Dodge and others. And so we found that we were able to teach children about – to identify their feelings, and also it includes personality types as well, so they can – various doll – well, they're characters who are dolls, or play things, you know?

**MS ABRAMSON:** Yes.

**MR BRETTIG:** Things you can play with. And so they get a better understanding of different personalities, and why people are different minded, and it helps them in conflict resolution and understanding and all that sorts of things. And also we obviously learned a

lot about trauma informed practice, and trauma informed – and trauma responsive practice; how to respond to children that have been traumatised at home. I started out as a teacher many, many years ago, and, you know, I had no idea what these children were experiencing in their homes before they came to school and why they couldn't learn because they were, you know, really, really traumatised. So we developed a concept which mentors people within the school, teachers within the school to be able to learn about trauma-informed and -responsive practice and be able to relate differently and change the whole culture. We started calling it the wellbeing classroom. It's now moved into a whole of school approach. So it's really changing culture, the whole culture of schools, and we're just in the process of finishing.

We did an evaluation initially at a school, and it showed that there was, you know, an improvement in feelings, vocabulary and in the child's sociometric data show that the behaviour was changing as well, and now we've just had another evaluation which – a draft report. We've got some of those reports here if you want to see those – which has over a whole school and three years we've seen bullying reduced by about – I think I've got the exact figures here somewhere. Well, the numbers of bullying issues reported in 2016 were 43, and the number recorded in 2018 was 22. So it's been kind of a decrease in bullying. And school attendance also increased from 89.6 per cent in 2016 to 91.8 per cent in 2018.

That might not seem a large figure, but when you consider we're probably dealing with a small population who have really complex issues it probably is significant. And also the other thing that we've seen is that it's a lot about leadership. It's about school leadership. It's about staff leadership, but it's also about student leadership. And within the school context we have seen the development of students as wellbeing leaders, and they came up with the idea that they wanted to be wellbeing leaders within the school.

They would call themselves wellbeing agents. They would meet fortnightly, and they would talk about the issues within the school, and they talked about how they can respond as peers with other students who are struggling with issues, and they were even invited by the school to speak at the staff meeting about how the staff were doing in terms of implementing wellbeing in the school which was a fantastic experience for the staff as well as for the students.

So both of those windows of opportunity for early intervention and prevention are significant, and I guess I would – we would see that it's really important that in terms of investing in the early years, that to keep developing that approach which will save, you know, mega dollars down the track – we continue to work at trying to get government to understand the significance of that and to develop it and to fund it because – and also that funding, I guess, because it's about developing communities, we really need non-government agencies working with government to develop those communities and see a significant change within our society.

**MS ABRAMSON:** Thank you.



**PROF KING:** Thank you. Just one then from me. So the intervention program for family support – so you’ve got a reduction in vulnerability population of 10 per cent. Again, this comes back to Dr Raven’s discussion that we had earlier today. And I understand the issues of attachment and attachment therapy, but the program can’t address the underlying issues – no. I’m making an assumption. Does the program go further and address the underlying issues that may be facing families?

So you mentioned domestic violence. The program, presumably – can it address things like the causes and consequences of – it can address some of the consequences. Can it address the causes of domestic violence? So if you have the intervention at the family level, you know, but it’s driven by poverty or by poor housing or by unemployment, to what degree do you hit a barrier, I guess, with those things?

**MR BRETTIG:** Well, obviously, the big concern with domestic violence is the cortisol released in the brain and the brain wiring that happens within baby, and – to give an example of somebody who has been through domestic violence on the weekend will present at school and talk to school counsellor or the wellbeing person in the school and say – and the school will have some capacity to respond to that, but if you have – it’s a family-centred concept.

**PROF KING:** Yes.

**MR BRETTIG:** In Ingle Farm the principles are we will take that person down to the family centre, and they are structured in such a way that they’re able to, you know, gather around that person for the amount of time that they need, and some of those people will need to come back to that centre, you know, three days in that week. Some others will come three days in a year because the issues are not so complex and so urgent.

So in that sense then you are able to work with the person and then refer to the appropriate services and so forth. I should also say, I guess, within the context of such a centre you have psychologists coming in who want to work with the whole community, so therefore we’re working with mental health people within that whole community. We’ve also made some strong connection with Child and Adolescent Mental Health Services, and we actually want – in one situation we have got Child and Adolescent Mental Health Services people coming into the centre one day a week, and we want to see more of that happening in other centres.

**PROF KING:** But let’s say the underlying issue – say inadequate housing or crowded housing, are you able to address that? Are you able to link in housing services or anything like that, or is there a boundary there?

**MR BRETTIG:** Yes, you are. And do it in a way – I guess the problem for a lot of people who have been traumatised is they just keep getting retraumatised by the services, and so if you are able to give a person significant time to talk about their issues and then be able to work with them and connect with the housing support that they might need, yes, you are able to do that if you have people – in a sense, you know, we talk about real

general practice service. If you have general practitioners, practitioners working – or family support practitioners, let's say, they have skills, and they are able to make those referrals, and within the context of a team if you have at least three or four or five professionals in centre, you have the capacity to be able to make those warm referrals so that they do get the support they need.

**PROF KING:** Thank you.

**MS ABRAMSON:** No. Thank you very much.

**MR BRETTIG:** Some of that documentation is in some of these documents.

**PROF KING:** Well, if Lawson is able to have a bit of chat to you because you said you also had some drafts.

**MR BRETTIG:** Yes. Okay.

**PROF KING:** So, Lawson, if you can – next we have Brad Morton.

**MS ABRAMSON:** Hello again, Brad.

**MR MORGAN:** How are you?

**MS ABRAMSON:** It has been over 12 months.

**MR MORGAN:** Really? It feels like (indistinct) you guys.

**PROF KING:** And if you can state your name, organisation you're representing and any opening remarks.

**MR MORGAN:** No worries. My name is Brad Morgan, and I'm from Emerging Minds which is a national organisation based here in Adelaide, and our focus and dedication is really focusing on the mental health of infants, children, adolescents and parents and families. From an organisational perspective, from the outset, the beginning of the organisation, the intent was to bring together in a single organisation family members with lived experience and professionals who engage in working with children, adolescents, parents and families, alongside researchers and policy makers. And the real goal for us as a national organisation is to work together with these groups to identify policy workforce practices and interventions to better meet the needs of infants, children, adolescents and families.

So some of our major work that we've undertaken and one of the big pieces of work is we're funded at the moment by the Commonwealth Department of Health to implement a National Workforce Centre for Child Mental Health, so it's just a fairly new program, and that's in parallel to the Be You program by Beyond Blue which is focused on education and care settings. We're focused really on health and social services, and probably how I

would frame it is the home and community environment and context in which children live outside of the school setting. That's probably the best way – I guess where we put our energy and effort and work alongside that program. Other pieces of work that have been fairly significant for us has been the National Children of Parents with a Mental Illness initiative. So we led the development and implementation of that from late 90s through to 2017, which has since been transitioning into the workforce centred program, as well.

So, just some general comments, just congratulations of the draft report, and we're very pleased to see quite explicit attention to the needs of children, ranging from early childhood to adolescence, but in particular the needs of infants, toddlers and children under 12 in relation to the recommendations. We've put in, obviously, a submission, but also responded to the draft, which is late. Put it through, but really today I wanted to put emphasis on a couple of areas which I think there has been some attention paid to, and other hearings, but just specifically a couple of items, rather than everything that as in the report or in our submissions as well.

So, the commenting I'll be looking at is really looking at reports of us developing integrating and expanded system of support for early childhood mental health, and primary school aged children mental health. And that really – looking at our system is looking at children at risk of, or experiencing mental health difficulties themselves. And the other area of work is really just in commentary around supports, and the recommendation around children of parents with mental illness as well, so just some reflections on what we have experienced so far, and maybe some ideas moving forward for that as well.

**MS ABRAMSON:** Can I also put on your list; we're interested, of course, in your views on the early childhood test, emotional and social wellbeing that we recommended.

**MR MORGAN:** Yes, I could do some comments on that as well, and then I'm going to a workshop in a couple of weeks on that, as well. I think I'll start off just talking about expanding systems of support, so that idea of children who do have prior experience in (indistinct) at risk of mental health difficulties themselves. So, as you'd be aware, there have been a number of investments made in those sorts of (indistinct), across health, across social services, across education, across Commonwealth, across state governments.

**MS ABRAMSON:** Yes.

**MR MORGAN:** And I think the common thing, I guess, from a national perspective was we know that many of them are working well, but there are sort of some bigger picture issues, I guess, which you've unpacked across those that are reflected in broader issues around our health system as well, and I think overall that's reflected alongside some commentary around social (indistinct) of health, which play an important role across adults, but also the children of those adults who are exposed to the similar sort of levels of, I guess, poverty and socioeconomic inequality which contributes to that, which I won't comment on today, I think there's been commentary on that. But I think, probably,

in relation to servant systems, I guess what we are particularly concerned about is, really, that miss-match between population need and actual services, and I think the cascading effects of that across a whole range of service systems, particularly in childhood and adult services as well.

I guess when we think about a cascading effect, I guess the analogy, or the examples of that would be (indistinct) for example, are the (indistinct). In relation to, I guess, we've got sort of that evidence only, less than 50 per cent of children who would meet the pointy end thresholds of diagnosis, for example, get access to any treatment or adequate treatment that would address the need of that pointy end, and so what we notice with services from spoken between them is, the consequence of that is the services that might not be funded to those services are seeing those children, and aren't able to offer that level of comprehensive, integrated support that brings together health, education or other services that need to be brought into that system.

So, a consequence of that is that we're not offering, I guess, offering an adequate support to make a change to a lot of children's mental health, and some just aren't accessing any of that support, as well. And I think that comes back to some of the commentary around – there's an issue around identification, which is one small component, but I think what we also hear is those that do identify the issue don't have anywhere to go with that, which probably comes back to some of this, I think, to work through which we talk about the social and emotional wellbeing check.

**MS ABRAMSON:** Yes.

**MR MORGAN:** The other issue, obviously, that comes alongside of that is the size and capacity of trauma in the adolescent mental health workforce in general. I know there was some recommendation around child and adults in psychiatry, but I guess there's also other workforce groups, including allied health and peer workforce, as well. And I think, probably, even in the context of peer workforce, I don't think there's been much attention paid to that in general, around what role and opportunities there are in the – outside of the adult sector, or potentially they'll integrate some of that, sort of, work too, then, though around impacts on parents, families and children in the one place. So that's an opportunity which we've commented on.

And then I think the other commentary in our exploration with some of the (indistinct) and mental health professionals out there is because of the thresholds and lack of resourcing in those services, often infant, child and (indistinct) are bundled together as prioritisation naturally goes to those that are the most (indistinct) presentations, and they tend to be in adolescents. And the consequences of that is, children who are quite severe don't get any support, because they're not going to be the same level, I guess, in risk in the context of that severity in adolescents. But also within that is the workforce who's in that specialist group, I guess you'd want them to be specialist in infant, child and adolescent mental health, is they sort of feel like they're being deskilled, or don't have the skills to work with children under 12, because they don't get the opportunity to actually

see them at that point again. So it's a very challenging area of work that needs, I guess, to address some of those overarching issues of lack of access.

And I think within that, I guess, we see it as an opportunity, that it's going to take a while for us to build a workforce in this area, it needs to be part of that broader workforce strategy, based on some of that population health guard that we know there is. It's also an opportunity to think about where is the best place to address those needs, and who else can be brought into that space. I think we've had a system that's been quite driven around psychiatry, allied health and nursing. There are other opportunities to bring in other allied health professionals, but also peer workforce and some of the social services in that area of work.

So I think that's the one area, I guess, that we, sort of, concerned about. But I think the other, underlying concern we've also identified is a really low level of child mental health which we're seeing in the community, more broadly, but also in the professions, including mental health professions around what actually is it. So, some of the challenges we've heard is when we – and we've done some actual research and exploration into this, is when we actually think about mental health, people automatically jump into mental illness, and mental health conditions. And so (indistinct) the discussions we keep having about supporting mental; health tend to be very oriented around identification of conditions as opposed to opportunities to nurture and support good mental health.

And conversations in the media and in the community, I think, that have been had in the past, tend to apply explanatory models of adult mental illness onto children, and the consequences you're aware of, where things can't be pressed in relation to this area of work. And I think, just in general, what that sort of flow-on of low child mental health literacy is obviously a community lack of commitment to this sort of area of work, and then when we do book commitment in, it tends to be oriented about they pointy end, as opposed to the investments of prevention and intervention. We also don't know what's the difference, and that's just what's the difference between normal developmental challenges and things that families go through, versus what actually do we need to pay attention to, and how do we help that to happen, and I think alongside of that is also knowing about vulnerability and the types of experiences that increase vulnerability but not yet present as challenges, emotionally behaviour yet.

So, in early childhood, we know things such as exposure to adverse childhood experiences, and accumulation over time results in, sometimes, presentations, so these difficulties coming out in psychological distress. But that might not appear in an infant yet. It might, but it might show up in late childhood, or it might show up in adulthood. And so, it's accumulation over time of those experiences, and so I think for a lot of the investments and practices that we're looking at, there isn't a magic fit, I guess. It's sort of looking at practices that really hone in on daily lived experiences, of children in the context of which they live and learn, and what are the practices that might change that, or buffer against the impacts of some of those challenges.

So I think some of the areas of opportunity we see, and this is just on a couple of examples, is, I guess, expanding a bit more of a focus on the opportunity, particularly in primary care settings, around integrated systems of support for children. We notice, sort of, quite a lot of attention on education settings, which are an important place for support. We also recognise there's inherent challenges and risks in that space, as well, and that sometimes the aim is bigger health – mentally healthy education settings and support good mental health, but we also know that is not experienced by all children, and that means they can also be a source of discrimination and exclusion as well. So, overall there needs to be that sort of lens on the education system that's important, and extremely important, but not the only place for us to be offering support.

General practitioners – I know we had some commentary before – we do perceive them as playing a really important role. They're a uniquely placed profession that operates across the lifespan. They're the ones that are exposed to knowledge about what's happening with family more broadly, so connecting the dots between what might be happening for the adult and then thinking about what's happening for the children in that context or vice versa.

So I think in general we would see opportunities to expand their role and support that role, and that needs to be multi-layered. I think as Caroline was saying earlier around that role includes assessment skills and training development which we're working on through our program, but alongside of that is incentives in many forms to wrap around and support that work to happen, but also is bringing into that space some of those services and opportunities that haven't been probably as well utilised.

We've obviously got programs like psychological strategies in that internet system, but there's also a question that needs to bring in some of those social services or adult services into that space, and so some of the work we've been exploring, and there's examples in Australia but also internationally is an idea of medical home and paediatric medical homes which, in America, is all around paediatricians, but the primary care provider in Australia tends to be general practitioners, so building up some of that paediatric skill level in general practitioners as a primary entry point which families rely on and trust a lot of the time to respond to that. So there's some opportunities there.

But alongside of that, the GP's is, when they're identifying or exploring, there's issues they describe nowhere to go, so particularly for the under-12s we talk about - I think we've got examples of where they had - children in very severe distress, but no one will see them, and so they're just sitting and holding and have to wait until they're an adolescent simply until those presentations are so severe that they can activate a system around them and they don't have the confidence to manage those issues and can't get supports.

**MS ABRAMSON:** Or worse, some of them are in the justice system.

**MR MORGAN:** Exactly. Yes, so I think there's an opportunity, I guess, to emphasise the role in more of that setting.

**MS ABRAMSON:** Yes.

**MR MORGAN:** Or those settings in that report we could do a bit more and set up some systems in parallel to some of those other recommendations in schools, and even the connection between those as well.

Another area we wish to comment on was recognition of the need to support children of parents with a mental illness. So as I mentioned before, there was a national initiative which ran from the late 90s through to 2017, as in transition did to this program, most of the elements of it, and that work has worked quite collaboratively with a whole range of international initiatives that are trying to progress a similar lens, I guess that idea of a two-generation focussed approach, or even more, around how do we address and parallel the needs of the adult who's a parent, alongside the needs of the children.

And in Australia we've had that work complemented with a range of state-government funded initiatives as well, not in every state, but for example in Victoria there's a families of parents with mental illness strategy; New South Wales a (indistinct) strategy which is soon becoming a family-focussed strategy, and Queensland and WA have had different sort of, probably not as well-resourced opportunities but some systems of that.

But generally I guess in relation to practices interventions that are being used internationally, locally, I guess characteristics of those is a recognition of the diversity of that and the size of that population we're talking about, so in Australia we're talking about over a million children who have a parent or live with a parent in any 12 months where there's a parent with mental illness.

And I think the message we sort of unpacked around that is that their needs are so diverse. There's children that are thriving, there's children who are vulnerable and there's children who are in contact with child and adolescent mental health services, child protection systems and so I guess, you know, the message behind all of that is, there's not a magic fit or program that's going to work for that population. They're as diverse as anyone in the community.

So the characteristics, I guess, of the interventions that have been implemented internationally, but also locally, are those that aim to contextualise both and understand the strengths and the vulnerabilities in the child's daily life and context.

So models that we've sort of been looking at is, it takes into account strengths, and knowing that there are process that - there's a lot of families have lots of difficulties and that's, I guess, more normal than not, to be honest, where you're looking at strengths of the family and networks around the family have activated to support children to remain or be able to respond to that.

So, and then I think intervention is sort of a parallel to that. The ones that seem to have the best evidence are those that aim to identify those strengths in the networks that wrap

around the family and deliberately pay attention to how do we keep them there when things might get bad, but also parallel paying attention to some of those vulnerabilities that are present as well and how to reactivate networks of support whether they're informal or formal for the family and the children.

As I said, the two-generation approach also is a very strong feature of those practices, that they can't separate individual adult recovery from children's needs.

**PROF KING:** Yes.

**MR MORGAN:** And at the moment we have a system that does, so as an adult, and we spoke to lots of parents when they enter into adult mental health service. It's a surprise to them, or many of them, that they're not even asked about their family or their children or their parenting and that's not brought into it, and for others they've had a really negative experience where their past is that their children have been removed or they've been judged negatively. So getting a balance in that space of creating a context, a conversation that enables that strength-based focus, but also we can address some of these vulnerabilities here as well and activate the supports that are needed.

And then in general the processes, I guess, of these interventions that have good evidence, it's underlying that as they aim to strengthen processes of family problem-solving and linking indication which assists in problem-solving. So when we're looking at those interventions it's recognising that we're not going to get a magic recovery from mental illness in a parent.

Recovery takes time and it means different things for different people, and so the idea is how do we deliver processes that enable problem-solving to address the challenges and the changing challenges that families have, but building capacity within that family to activate the networks or facilitate processes. So that's what the evidence around interventions are.

And then alongside of that is exclusive attention to relation or how to solve mental illness and mental health needs in the family, and parenting roles and those sorts of things. They aren't exclusively addressed in, for example, our mental health service will address and talk about employment, and talk about participation inclusion, but it's very rare that a conversation around how is a family going, how is the treatments impacting on how you feel about getting up in the morning and getting school kids to school, those sorts of things.

They aren't routine. We've got resources that can help that to be routine, but it's not an expectation of services to do that, so for some families they talk about having a really good experience of that being part of their recovery, but others say, 'No ,well, it wasn't even raised and discussed and we actually had really negative experiences of it'. So I think that represents, I guess, what we struggle with, a system nationally trying to operationalise some of these interventions and practices and programs is - they're



unfortunately driven by local champions who lead with passion, but it's not an expectation of services that they provide these types of services.

**MS ABRAMSON:** In fact, it's interesting on the relational point. We did receive quite strong criticism that we hadn't actually covered the relational aspect of mental illness, and our answer to that was, well, it was actually in the carer's chapter, so it was actually, we had dealt with it quite explicitly.

**MR MORGAN:** Yes.

**MS ABRAMSON:** But, you know, we did take that on board, that people said, 'But in your earlier part you hadn't actually talked about it'.

**MR MORGAN:** Yes. Yes. And I think that's part of the challenge, I guess, we've flagged overall, is around how we describe people in relation to the mental health system packages.

**MS ABRAMSON:** Yes. Well, we struggled at - - -

**MR MORGAN:** And we have carers and it's a really - unfortunately it's almost in the context of you are either/or.

**MS ABRAMSON:** Yes.

**MR MORGAN:** But also a child isn't a carer. They are a recipient of care of the consumer potentially if you want to frame it in that type of language, and vice versa, that what we hear from a lot of parents who might be labelled as a consumer, and also a carer of a child who has a mental illness, a child of a parent with a mental illness, who I'm also managing.

**MS ABRAMSON:** M'mm.

**MR MORGAN:** So I think challenging this idea of consumer carer as the - not - they are important identities, I guess, in the definitions that we have, but we need more than that to reflect the reality of context and the roles and multiple roles that people play simultaneously that we are just recipients of care. We're also providers of care in lots of different ways and context in our relational roles and so I think that's where some of that challenge comes from, a lot of the way with model systems.

**PROF KING:** Can I follow up on the social and emotional wellbeing checks for, at the pre-school level. When you mention low level of literacy around child mental health, and putting in adult lens on to child issues, I mean, and you've seen the push back that we've received. You will be aware of earlier recommendations for these sort of checks that have been unsuccessful and been opposed, and you'll recognise the role. On day one we had unsavoury, in my opinion, headlines in the press which I mentioned earlier on.

How do we deal with that? Is it just a matter of literacy and understanding around social and emotional wellbeing for children, or - because I fear if it is just that then we've lost, you know.

**MR MORGAN:** I guess in my mind, I think there's a few strategies, I guess in mind. I think we've done some work looking at child mental health, especially with the frameworks (indistinct) America, and they sort of explored the nature and the order of the way you tell the story. About these types of issues that result in positive changes in community understanding of these types of issues, rather than decreasing, I think, is sometimes what you see.

So I think the example made in these two-stage studies and things - child protection, for example, where ads with good intention about child protection and not little children, for example, have actually decreased community political commitment and interest in that topic. They would have been better off not doing anything because the messaging that the community - went, this is hopeless. We can't do anything about it, and so what we do in that is we ignore it to some extent, and so I think similar risk could occur in relation to child mental health.

Because if we start from illness, we will hit the same problem. But also, alongside of that, I think that sort of risk like social and emotional wellbeing checks is - the nature of the check really needs to be framed, and I guess if I'm (indistinct) development.

**MS ABRAMSON:** Which is what we - - -

**MR MORGAN:** And that's what we've been trying, I know, and I think that will be important, I guess, a collective response from different professional associations and audiences, including family members to talk about - I won't actually be talking about here. One of the questions that we're asking, because I think we sort of get shrouded in this idea that we're going to be diagnosing children with all these issues, and I think within that is that sometimes that might be an important thing that we do need to attend to find some circumstances that this little child needs specialist intervention from the medical system around some of these issues.

**MS ABRAMSON:** Although interestingly, where we started from was about family support. So it's actually giving the parents, the caregivers, the tools they needed to assist the child.

**MR MORGAN:** And I think alongside of that is there are existing data sets that tell us quite a lot about children's mental health as well. And obviously, they're associations and they're not in a lot of the research, but if you look at the Australian Early Development Census, that was framed. There's been studies done in Canada, for example, where they track children over many years using a similar measure.

**MS ABRAMSON:** Yes.

**MR MORGAN:** And from the scores that are identified in early childhood or in the first year, around five, is that they can actually make estimates around which percentage of this population is likely to go on to experience these particular types of mental health difficulties. So we do have some of those measures that have potential to help us identify groups across that lifespan around there's going to be a likelihood that there's 20 per cent in this community that go on to experience depressive cognitive challenges, or this group's going to go well, or this - - -

**PROF KING:** Can I then tap on another point that you mentioned, which is you said when to intervene. But that's also been issue that's come up in comments on children. The claim, well, this sort of approach focusing on children means that you medicalise it, make clinical just normal life events.

**MR MORGAN:** Yes.,

**PROF KING:** And I understand there is a grey area of when is it just normal life events versus when is it something more than that. Again, how should we be thinking about this? Other than it's a grey area.

**MR MORGAN:** Yes. I think what we put forward in our original submission, which is sort expanding, is expanding our definitions of different population groups (indistinct). I think we've historically had a very linear, diagnostic pathway of prevention and early intervention support. So anxiety equals let's step back and look at prevention of anxiety, or an intervention for anxiety, or treatment for anxiety, rather than, I think what we're sort of encouraging, look at psychological stress and adversity as measures of treatment of mental health, and those continuums of those.

So in our submission, we sort of did a bit of a table list to say, well, we know that 50 per cent of children who are two to four years old are living in no adversity, and very low psychological distress. What they'll benefit from is overall sort of issues in schools and things that will support good mental health. But moving across that continuum, we also know there's children who are doing well, but are exposed to high levels of adversity and vulnerability in the family or community context who would benefit from prevention activities that might not specifically address the social and emotional elements of ending the actual issues, because they haven't got any yet, but are addressing some of those, I guess issues that are disrupting the family more generally and how we reduce the level of that disruption over time.

So hence, some of the practices from the - for example, that (indistinct) work would be useful in those areas. So selective prevention is how we describe it. So I think it's expanding conceptualisations to make sure we're paying attention to adversity. It's such an important determinant of children's mental health and that - we need to measure that alongside just psychological or symptoms that are preventing - because okay, they need equal attention.

So we framed it as one of the most expensive prevention interventions is intensive family

home visitation for parents who might be going through - they're really expensive. They're not cheap, but the intention is those longitudinal outcomes that come from those that have experienced 20 years down the track, or 40 years, are adjusted, or those sorts of things, and I think - I think for me is expanding - the Stepped Care Model is good, but it needs expansion to take into account adversity as another step in that work, which is what we're proposing.

Because at the moment, I think the Mental Health Commission Review, and in this one, I think, when we framed what's been framed as Stepped Care and the assumptions around the types of interventions offered, I think overall, based on a diagnostic model rather than integrating those two things. So when I think about prevention, I think what's listed on there is low intensity, self-directed supports as opposed to actually, in infancy it might be the most expensive intervention for children who are - infants who are experiencing challenges, yet that we know are likely to - so it's just, it's more the type of interventions I think that we activate and offer that need to take into account more than just the presenting symptoms.

I think that's sort of, I guess, what we would reflect, and I think some of the work that was done here locally, so - and that's what we referenced in our report. But I can send you some more information. It's just the modelling around how many children do fit into these different areas of work and who might benefit from this particular type to be a basis of, I guess the overall work or strategy. How many people do we need who could deliver it? All those sorts of things would be really good.

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

**MS ABRAMSON:** Thank you.

**MR MORGAN:** Thank you.

**MS ABRAMSON:** Well, I'll have a good read of your submissions. So thank you.

**MR MORGAN:** And like I said, I'm always happy to share more info. Thank you.

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

**PROF KING:** And Lucy Trethewey.

**MS ABRAMSON:** This is the book that Lucy - - -

**PROF KING:** We've got the book.

**MS ABRAMSON:** Yes.

**PROF KING:** But Lucy - - -

**MS ABRAMSON:** Yes. No, that's her nom de plume.

**PROF KING:** Yes. And if you're able to state your name and if you were - if you are representing an organisation, what organisation that is.

**MS TRETHERWEY:** Hi, my name's Lucy Trethewey. Thanks for having me here today. I'm a children's author and I've worked in mental health as well.

**MS ABRAMSON:** Lucy, you might need to just speak up a bit because the microphones are not for amplification, they're just for the transcript.

**MS TRETHERWEY:** Thanks. Yes, thanks for having this opportunity to talk. Have you heard of the identified patient, the family scapegoat, the symptom bearer? Have you heard any of those terms? I'll just explain them briefly. So, an identified patient in a clinical term is one family member in a dysfunctional family that sometimes expresses the family's conflicts through their behaviour.

Sometimes it's very overt, sometimes it's covert, sometimes in boys it can look like ADHD or (indistinct). The behaviour in girls, they can be very quiet. That's from psychiatric. In family systems therapy, they call the symptom bearer, and the symptom bearer kid is the one that becomes the identified patient in the dysfunctional family, becomes the scapegoat. The family says this is the sick one in the family. A lot of people can't recognise it when it happens. Sorry, I got really - I got myself confused. I might just ad lib.

Yes, so it's a serious dysfunctional family system, and it seems very narrow and probably not - you probably can't see it in the big picture, but in the big picture, it actually affects a lot of things. Because a lot of scapegoat kids, symptom bearers, identified patients, are what fills up the mental health system.

**PROF KING:** Yes.

**MS TRETHERWEY:** And they also become a way for that family to pass on intergenerational violence, intergenerational addiction or violence, or just a personality disorder that gets passed down. It gets passed down through that family system. There's also, they say, the lost child, which is the child that might be trying to make themselves very small and quiet and avoid interactions with family members and basically disappears, becomes a loner or is very shy.

So I went looking – I worked in mental health and I picked up – because I knew some of the kids I looked after had grown up in families like that, the scapegoat kids. Pretty severe scapegoat kids. They ended up in the mental health system. I supported two, and the services identified them as the mentally ill one and the parents would come in and identify them as the mentally ill one as well when they were bullied at home and abused at home, or put down, or shamed, or mocked, or ostracised, or separated deliberately by their parents. It happens in wealthy families. It happens in all types of different families.

So sometimes those kids can end up diagnosed with a mental illness. I was kind of happy but then I spoke to some and they said it's not a good thing, either, that complex PTSD is going to be added as a diagnosis for children. Have you heard that? A new diagnosis or something, which might help people become more aware of this in kids?

**MS ABRAMSON:** We certainly – Stephen and I have not focused on the clinical side. We do have Harvey Whiteford, who is a psychiatrist. So Harvey might be aware of this, but.

**MS TRETHERWEY:** Yes. So I went looking to help a child who I'd seen getting bullied at home by two very high-functioning, educated – really presented nice parents, but they really picked on one kid and it's all very oppressive. No one can talk about that when it happens in a family. I don't think services are equipped to deal with it. So I went looking, went looking, asked people what to do. I mean, they do have a complex needs system which deals with that sort of dynamic, but the thing is, the parents would never admit to it and they won't attend that, and they would rather blame the kid, and so I wrote my book, *Scapegoat*, and then I had – it got changed when it went to the publisher. It got edited. I would write it differently, and everything to date, to me, is screaming we need the village to step up. We need the extended family to sit up. We need the aunties, the uncles, the grandparents, the cousins, the neighbours to step up to help kids, to prevent mental illness. We're very isolated at home with your parents. Family dynamics are so weird now that you can't get anyone to disrupt it.

**PROF KING:** Yes, whereas you'd expect that in the extended family there would be people there who would be aware of what's going on in the nuclear family, for want of a better word, and you would – you know, traditionally, you would expect them to step in, but they don't, now.

**MS TRETHERWEY:** Yes, and I think in the past – well, I don't know if it's always happened. But I think in the past people were more confident just to jokingly say something. 'Don't pick on her' or 'don't throw that at her' or 'don't be mean'. But we're really nervous now to pick it out, and I am too. I've actually been a part of this problem. I've joined in on picking on a kid, and I've seen it and I will do it as well because that's the dynamic of the family, and that kid will end up with a mental illness or will have – become a bully himself. There's a research paper I've read that children who are the siblings of severely scapegoated children have empathy deficiencies.

**PROF KING:** Okay, because I was actually about to ask that. So is – yes. Would it affect the other children as well? Because they're presumably joining in on the scapegoating activity. Presumably they're doing that because again, they're facing pressures from the parents.

**MS TRETHERWEY:** Yes, and they learn that they – that bullying behaviour, you hide it  
- - -

**PROF KING:** It's acceptable.

**MS TRETHERWEY:** You accept it, you hide it, and that child, to survive, has to learn that that's okay, to survive, and that will repeat again, and this has consequences that are far-reaching and it's very learnt, highly covert behaviour, and I've seen it play out in weird ways in quite high-functioning educated people as well as lower-class socioeconomic. Bizarre situations. So I do think it affects - and it's relevant to this Commission as well.

**MS ABRAMSON:** Can I ask - bearing in mind you've been so patient because you've waited all day to give your evidence - what are the sort of things that you would like us to look at, Lucy? What are the things that from your perspective - because you've taken the trouble to come and make a submission to us, what would you like us to concentrate on?

**MS TRETHERWEY:** I think we need a message that the family and surrounding people have to stand up and government can't fix this. I'm sorry. It's almost - maybe government can help by funding awareness of these family systems and how they work, and that can be done in a pretty, nice, with a bow, 'look at my lovely book' or 'look at this lovely movie' and 'look at this child here' in a media type of way and then the people go, 'we do that at home, we didn't realise we did that', or the kid will actually think, 'that's what's happening to me at home. I didn't realise it wasn't my fault. I thought it was all my fault', or the other kid will realise, 'I never stand up for my brother'. I mean, like, you can portray it. You can portray it and show it.

I also think people are not educated or nuanced enough to pick up on it. Systems, mental health systems, even social workers, psychologists, child people - they don't mean to, but they will actually identify that child as the problem in the family and they will crunch down on that child and say, 'you're the mentally ill one, you're the one that's causing all the problems', whereas you need to take it right off that kid and say, 'this family is in this boat together and this kid is showing what's wrong in the family. We need to talk about that'. What else?

**PROF KING:** Yes, because it's - yes. What - so it is slightly different, but someone else in one of the earlier hearings gave evidence on - similar but different, if I can call it that, where one of the parents - often associated with a family that's in - dysfunctional and breaking down, one of the parents will use the children to gang up on the other parent, and again - and there's evidence there that that has negative effects - psychological effects on the children, obviously, who are being used by the one parent, and again - but how do you respond to that? Well, yes, there's no easy answer, and I guess it's exactly the same.

**MS TRETHERWEY:** You can tell kids that that's the triangle. You can describe it to children and they will - kids have the intelligence to pick up - kids have actually told me that and they will use children's language to describe it, and they're smarter than us. They will actually point it out and the parents will push them down and silence. The services will push them down and silence them. But the kids will say, 'we're communicating like a triangle'. 'Mummy tells me this about daddy, but no one will talk

to them and then they go through me.’ So kids are used to communicate passive aggressive - - -

**PROF KING:** Yes, behaviour.

**MS TRETHERWEY:** - - - perversely toxic hidden messages, but the kids need to be validated.

**MS ABRAMSON:** And what you’d like us to do is to think about that in the context - when we talk about children and the support for children, that there is this type of dynamic and we need to be aware of it.

**MS TRETHERWEY:** Yes.

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

**MS TRETHERWEY:** Can I read the reference I got from someone?

**PROF KING:** Please, yes.

**MS ABRAMSON:** Absolutely.

**MS TRETHERWEY:** So this is from Ueli Kramer, the president elect of the European Society of Psychotherapy Research. He’s a psychiatrist. He says my book,

*It may foster emotional awareness and help them to stand up for themselves. As such, it may contribute to tackle the effective roots of bullying and help prevent long-term mental health problems.*

Yes, and I’ve got other ones here from psychiatrists, and what it’s trying to say is if a child is told ‘this is not your fault’, it changes the confusion in their brain and they might actually sit back and think, ‘it’s not my fault, I’ve been trapped in this family dynamic’, and you can do it in child-friendly language. You don’t have to do it in that kind of psychiatrist – you can do it in little animals.

**PROF KING:** In a sense, your book is doing that, yes.

**MS TRETHERWEY:** Yes, and that provides relief to a child’s brain because the child needs to know that it’s not a little kid’s fault that he’s been – you know, it’s not his – he doesn’t need to take that on board mentally, and he needs strategies to learn to survive that mentally because otherwise these kids will end up repeating it or mentally ill, and I’ve seen that happen.

**PROF KING:** Or they become traumatised.



**MS TRETHERWEY:** Yes. I've seen terrible things happen. So I would really wish, if anything comes out of this, that would be to stop that. Sorry.

**MS ABRAMSON:** No, I understand, and thank you very much - - -

**PROF KING:** No, thank you.

**MS ABRAMSON:** Thank you for the books as well. Thank you.

**MS TRETHERWEY:** Yes. So, the solution in my book is government interference and I got criticised for that.

**PROF KING:** Okay.

**MS ABRAMSON:** Thank you.

**MS TRETHERWEY:** Okay.

**MS ABRAMSON:** And thank you for being so patient.

**MS TRETHERWEY:** It's all right.

**MS ABRAMSON:** You've waited all day.

**MS TRETHERWEY:** Thanks.

**MS ABRAMSON:** Thank you.

**PROF KING:** Now, at the end of these hearings we always ask if there's anyone else on the floor who would like to put anything on record?

**DR BENJAMIN:** I got squeezed for time this morning so I wanted to add to my presentation.

**MS ABRAMSON:** Excuse me, I've got a 6 o'clock flight.

**PROF KING:** Yes. So, unfortunately, it's really just for people who haven't had a chance.

**DR BENJAMIN:** It would only take me about 30 seconds to say it.

**MS ABRAMSON:** Is it something that you want on the transcript?

**DR BENJAMIN:** Yes.

**MS ABRAMSON:** Okay. Well, we've got probably got – we've got a room booking issue but we've probably got about three minutes or so.

**PROF KING:** Can I check first if there's other people.

**MS ABRAMSON:** Is there anyone else that would like to speak?

**UNIDENTIFIED SPEAKER:** There was a couple of times today when you were asking for extra responses and I was just wondering whether or not there is an invitation at all to be able to respond to some of those questions in a written way?

**PROF KING:** Yes.

**MS ABRAMSON:** There is. There's an easy way for you to do it and Lawson is here. He's our staff member here today. But we have a comments section on our website and I think that would be the most effective way and you'll find it with the navigating to pc.gov.au, but Lawson, would you be kind enough to give some details?

**LAWSON:** Yes, you can come and see (indistinct words).

**MS ABRAMSON:** Thank you. But absolutely you can respond.

**PROF KING:** Okay. If you'd like to make any brief comment then on the record.

**DR BENJAMIN:** Sure. Do I need to go the microphone?

**PROF KING:** Yes, you'll need to for the transcript and you'll need to reintroduce yourself so that we can - - -

**DR BENJAMIN:** Tom Benjamin, Medical Consumers Association. Just adding to the end of what I was going to say this morning because of a rush for time. One of the big dangers that I see from the step-care model is going to be a possible depletion of the Lifeline counsellors.

**MS ABRAMSON:** Yes.

**DR BENJAMIN:** Because if they can't see a career path for counselling because they're squeezed out by the Medicare Benefits Scheme giving psychiatrists as much as \$220 an hour basis plus a gap fee, who else could compete with a business next door that has a \$220 government guarantee and can peddle drugs while other people are making maybe \$88 an hour and you're out there having to charge people out of their pocket. No business can handle that kind of competition.

Once these Lifeline counsellors, who are there to get their placement hours up; they're not there just because they want to give back to the community. That's the retired group. The young ones that are there are trying to get those thousands of hours of placement in.

When they find out that guys like me maybe closing down our practices, they will see the writing on the wall. Why would they keep going to Lifeline? If they have any sense they'll have to get a day job. They'll realise that counselling is not going to be the day job. They'll have to keep that waiting on tables job that they've got now. Thank you.

**MS ABRAMSON:** I understand. Thank you and thank you for being brief.

**PROF KING:** Right. I will now – sorry, there's some official words that I need to say.

**MS ABRAMSON:** Yes, adjourn the hearing.

**PROF KING:** Yes, where are we? Ladies and gentlemen, that concludes today's scheduled proceedings. I adjourn these proceedings. The Commission will resume hearings later this month in Darwin.

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

**PROF KING:** Thank you very much for what has been a fairly long day.

**ADJOURNED UNTIL MONDAY 24 FEBRUARY 2020**