ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Melbourne Town Hall, Yarra Room,
90-130 Swanston Street,
Melbourne, Victoria

On Friday, 19 July 2019 at 10.00am

(Day 14)

Before: Ms Penny Armytage (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Ms Lisa Nichols QC
Ms Georgina Coghlan
Ms Fiona Batten

MS COGHLAN: Good morning, Chair; good morning Commissioners. Today's evidence relates to the topic of community resilience. It is important to consider this in the context of the broader terms of reference that the Commission must consider. Prevention of mental illness and improving mental health outcomes are raised in those terms.

In considering that, the Commission's inquiry's not limited to looking at the clinical system or the mental health system as it may conventionally be understood. Community resilience can be a protective factor; it may be important for young people, marginalised communities, or those collectively facing a crisis. You will hear evidence about each of these areas.

During community consultations, the importance of building resilience and promoting good mental health was a common theme. Factors that negatively impact community mental health were identified, including financial stressors, social isolation and loneliness.

Bullying, particularly online bullying, as well as stigma and discrimination, particularly for minority groups, were also identified as negatively impacting community mental health.

There were also several programs and services that were identified as contributing positively to community mental health. For example, Men's Sheds, community houses, community arts programs, sporting clubs, youth mentors and volunteering opportunities. What these programs have in common is that they provide a safe space that fosters social connectedness and a dialogue.

Through submissions, the Commission heard that people are disconnected from each other. There needs to be an increase in ways people get together.

In the course of the evidence today there will be a focus on innovative or novel ideas, including the way technology can be used to promote community resilience.

You will hear from Greg McMahon, who is the Executive Principal of Hallam Senior College and the Strategic Director of Doveton College. He has been an educator for 37 years. Mr McMahon will speak about his experience supporting the mental health of young people at school and

implementing programs at school relating to the mental health of young people, but also supporting the broader community.

Mr McMahon has a particular experience in programs known as Our Place at Doveton College and the implementation of the Berry Street Education Model.

You will hear from Emma King, the Chief Executive Officer of the Victorian Council of Social Service, or VCOSS. In the context of her professional experience, Ms King will address why certain communities in Victoria have or are at greater risk of having poor mental health, including the impact of socio-economic status and disadvantage.

Ms King will address the importance of early intervention and what might be done to ensure efforts are responsive to the Victorian community, including examples of interlinked, well connected and coordinated services.

Matiu Bush is the Founder of One Good Street and Deputy Director of the Health Transformation Lab at RMIT. One Good Street is a neighbourhood social networking site that aims to reduce loneliness and isolation in older people. He will talk about One Good Street and what it does and also other technological measures that promote connectedness for older people, all the while bearing in mind that face-to-face contact is where real connectedness lies.

Jane Anderson is a Latrobe Health Advocate, a role which provides independent advice to the Victorian Government on behalf of Latrobe Valley communities on system and policy issues affecting their health and wellbeing. It was a role established in response to the Hazelwood Mine Fire Inquiries. In her evidence she will address the resilience her community has demonstrated.

Ms Anderson will also convey the experience of the Latrobe Valley community in relation to mental health, with a focus on how certain interventions in the Latrobe Valley might also be effective in other places in Victoria.

Finally, you will hear from Professor Helen Christensen, she is the Director and Chief Scientist at the Black Dog Institute. She is also a Professor of mental

health in the Faculty of Medicine at the University of New South Wales. The Black Dog Institute is an independent medical research institute focused exclusively on mental ill-health across the life-span.

Professor Christensen will set out Black Dog's research programs, how it undertakes randomised control trials, how it applies the results of those trials and how, in particular, it implements interventions in schools. Professor Christensen has particular expertise in e-Mental health and will describe a number of innovative programs which the Black Dog Institute is delivering by way of electronic platforms.

I propose to call the first witness now. I call Greg McMahon.

<**GREG MCMAHON, affirmed and examined:** **[10.08am]**

MS COGHLAN: Q. Mr McMahon, you've provided a statement to the Royal Commission?
A. I did.

Q. I tender that statement. [WIT.0003.0008.0001] You are the Executive Principal of Hallam Senior College?
A. That's correct.

Q. You are also the Senior Director at Doveton College?
A. Correct.

Q. You were the Executive Principal at Doveton College from 2014-2019?
A. Correct.

Q. You've been an educator for 37 years?
A. A long time.

Q. Focusing on your time at Doveton College as the principal, but also as the Strategic Director now, can you just explain what your role is as Strategic Director?
A. A Strategic Director is building on the relationship between the school and all what we'd call the wrap-around services. So, if you go back to what we all went through, you had a school that opened at 9 o'clock and closed at 3.30. But at Doveton it's not that: we open at 7 in the morning, we close late at night. Within the school environment we have a community hub, if you like, that has

all these add-on elements: so, Early Learning, Play Groups, Maternal and Child Health, you've got services, Outreach Services, you've got an Early Learning, High Quality Learning Centre, and then you've got Adult Learning as well plus Men of Doveton, Women of Doveton, so there are so many other elements that are wrapped around the school.

Q. In terms of Doveton College itself, it opened in 2012?
A. The first full implementation was 2013 but it opened at 2012, yes, but they added on another element in the next year.

Q. It opened in response to the closure of four local schools in the area?
A. At one stage Doveton itself had six, but at that stage it was down to four, and they therefore closed and one school was built. It was part of the regeneration program within Victoria; similar things happened in Broadmeadows, for instance.

Q. When was the model called Our Place first adopted?
A. It was never called Our Place. It was adopted by the way our parents started to refer to the model; it was their place, and so Julius Colman, who's the Foundation philanthropic backer of the college, said "that's what we need to be known as". So, it became Our Place, it couldn't be the Doveton model going out to other places, it had to have something else, and "Our Place" just resonated with us all.

Q. I'll come to ask you about Our Place model at Doveton, but I'll just ask you about this first. One other model, if you like, that was implemented in 2015 was the Berry Street Education Model?
A. Correct.

Q. I'll ask you more about that later. So, you've talked about what Doveton College does differently to other schools. Can I just take you to a particular passage in your statement and then ask you about it. You say at paragraph 13?
A.

> "Doveton College seeks to support, foster and develop opportunities for all members of the Doveton community, including children, young people and adults."

So, can you just expand on that as a concept?
A. The best way I define it is, I grew up in the country, a place called Werrimull. Go to Mildura, turn left, if you hit the South Australian border you've gone too far, the furthest school from Melbourne. The school is everything to the community. But in places like Melbourne, the school is the school: has big fences and basically says, drop your kids, come back at 3.30 and pick them up.

In a place like Doveton that could never work because what you had was parents who had never been successful at school, or were off boats, out of Manus Island, places like that. So we had significant disadvantage. The barrier to entry for these people was the front door. And so we as a community said we have to reshape what that's about.

Research said, in Toronto and in places like England, things had to change if you're going to change the opportunities for disadvantaged communities. And so, this is Julius Colman's philosophy, implemented by June McLoughlin, Shannon, and the team out there of the Our Place team.

So if you look at it, it's a place-based initiative, the school is the place. It is taking disadvantaged communities where the postcode has determined outcomes. If you go back to the Jesuit 2015 study, you'll see those postcodes have never shifted: Doveton's always been in, if you like, the league ladder of disadvantage.

What the school became was the community centre, it was the add-on hubs that were built around it, and it's not a significant build. It became the centre of, if you like, what we would see as the opportunities for children, families and communities to flourish because they had the opportunities and they had the confidence to come into it.

And it was built around these five components: high quality schools - non-negotiable; high quality Early Learning and the Early Years wrap-around services such as Maternal and Child Health, Play Groups; out-of-school, after school activities for young people, and I'll give you an example: when I first got to Doveton, 7 per cent of young people did anything after hours, 7 per cent.

Now, my parents were taxi drivers, took us to sport, music, everything. My previous school at Parkdale,

basically kids did everything after hours, middle-class aspirants, but they, 7 per cent. By bringing in after school opportunities we've got it to nearly 70 to 80 per cent of take-up.

Then you had, for instance, all the wrap-around health and wellbeing services that were required, both allied health and health, and then you had the Adult Learning Volunteer Programs and After School Men and Women of Doveton Programs, so it's a whole range of things being added on to the central spoke, if you like, of the school.

Q. Can I just ask you to focus on what you said about the medical and allied health services. What you're saying is that those services actually exist in the school setting?
A. Yes.

Q. And that includes a paediatrician?
A. It does. I'll give you the rationale behind it. Young people have to be school ready, and school ready means they can't walk in with a back pack of disadvantage on their back if they're going to have an opportunity to learn, but many of our kids did, up to 50 per cent. And so, one of those big issues was diagnosis, understanding what were the issues behind them: it could have been cognitive, it could have been social/emotional, it could have been physical, it could have just been a cultural issue.

So, when we saw the number of students, and when I arrived at Doveton there were about 15 students on the program for disabilities, and when I looked around I'm saying, this can't be right, but there was no diagnosis of it. Our parents would not go to paediatricians. Why? You have to book in, there was a gap in payments, you had to travel, there are all these barriers.

So we said, there's the barrier, find the solution. And the solution was Monash Health with their paediatric fellows came in, and we said, but we need a diagnosis and they can't do that because they have to refer it to another paediatrician to get that, we went and got our own paediatrician. And so, she's in the school, we have a GP in the school, and that GP is in every fortnight with a nurse. The paediatrician's in every fortnight. We refer on and we get the diagnosis, and it's cost the school a small amount of money to do that.

The big advantage is, the parents do not need to go anywhere, they come to a place they're comfortable in, the school, and it's organised by my wellbeing team led by Amara Miles.

Q. You say in your statement that, as well as the paediatric service, there's also Child and Maternal Health, GPs, nursing, occupational therapy, speech pathology, psychology, podiatry, physiotherapy and social worker services?
A. Yes.

Q. In addition to that, you've got social workers and psychologists actually directly employed by the school?
A. Yes, we operate four within our team, but if you like there's the department team as well, what's called the SSSO. We have a speech pathologist and a psychologist there; two days a week for the psychologist and one day a week, speech pathologist. Then we have the Monash Health who have a community need to be out in the community and what they do is provide other services for us; we provide the location and the clientele.

Q. You say in your statement that Doveton College has 650 students?
A. Yes, well, that varies every day, I can guarantee you, we enrol every day.

Q. And that's from prep to Year 9?
A. Correct.

Q. And you have 75 children, roughly, in your Early Learning Centre?
A. At any day, 110 over the week, yep.

Q. One of the things you say in your statement is that parents are free to stay at the school all day.
A. Yes.

Q. Can you elaborate on that?
A. Yes, so if you walk into Doveton the first thing you'll walk into is a welcoming environment, so the receptionist, two receptionists, one of our receptionists speaks seven languages, so straight away one of the barriers of communication is broken down. Within that we have a coffee lounge and we have our engagement officers

from the Our Place team, two of them.

A parent walks in and they want to enrol or they want to look at a program, straight away our engagement officers engage them, and so, they can do their - we've got a series of computers, they can do their bills on, they can do their reference - sorry --

Q. CV.
A. CVs and things like that, so a whole range of things and it's really about that social interaction for a start, building the confidence and where they feel confident to come into the school and spend time.

The only place they can't go into is a classroom unless they're a volunteer and gone through all the training that comes with that. But they can spend that time in that area or they can take up Adult Learning, 200 mums learnt last year, or they can go into the other programs that are taking place like the Play Groups and I think the video later will show some of that.

Q. We'll get to that in a moment. I just want to ask you a couple more questions. You've touched briefly on the demographics of the community and the student population, and in your statement at paragraph 16 you say :

> "We have a diverse and often vulnerable student population."

A. Yes.

Q. Can you expand on that a little bit more?
A. Okay, within Doveton you've got a number of components, the school component is 650 young people from prep through to Year 9, then you've got your Early Learning component, then you've got your wrap-around services.

So, to give you an example, basically if you go through the testing, a significant number of our students have either one or two vulnerabilities under the AEDC testing, and it is about three times - when we first started it was about 50 per cent of kids had nearly two. I might be slightly wrong on that but it was close to it, significant, over and above.

Basically, we've got 52 nationalities I think, so

multiple languages. We've got about a 30 per cent mobility in the school on a regular basis, and we enrol and dis-enrol every day. We've got significant trauma in the school for a whole range of reasons, and then you've got people through the Department of Human Services, there are approximately 100 active cases at any time.

The Department of Human Services are basically at the school everyday for some reason: whether it's case management or picking up clients or other things. At any time we will have somewhere between 20 and 30 in out-of-home care, and these are young people less than 15 years old, so some of them have never been with their parents. So, yes, really significant trauma and disadvantage and complex, very complex.

Q. One of the things you mentioned was the idea of, I think you've said, a higher level of mobility?
A. Yes.

Q. And that's because it's a high rental zone?
A. Yes.

Q. So that you have people enrolling and then unenrolling frequently?
A. Yes. So, to give you an example I was talking to Deb Gibson, the principal, I was around there the other day, and they just enrolled two families of I think it was eight or nine students. I was just saying to a colleague here who was an ex-student of mine that at my previous school if I had two students leaving before census I would say, what is going on? We don't even count at Doveton until census day, there's no point, because you could have 20 come in one day, 20 go out the next day, so the mobility and the fluidity of people shifting in and out is significant.

Q. I said I'll come back to the idea of the Our Place model at Doveton. You've talked about that being a place-based initiative of the Colman Foundation, and you work in partnership with DET at 10 selected sites across Victoria - not you personally, but there is that partnership.
A. Indeed.

Q. And there are a number of other sites at which Our Place is currently being implemented?
A. Yes. So, Doveton was the first and out of that came

the Our Place concept, if you like, what had worked at Doveton. We understand that you have to have contextual understanding of the place you go into, but Julius in his workings with the Department of Education basically came to an agreement that there would be 10 other sites included under this Our Place model. They were all disadvantaged areas, so we've talking about Robinvale, Corio, Carlton, High Rise. You're talking about Frankston North. Then you've got at the present time, Morwell, a couple of sites at Morwell, and I might have missed one or two - oh, Seymour.

Q. And Officer?
A. Officer, Cardinia, yes, so all of those are the sites that are in progress of being either developed or have been developed.

Q. You've mentioned a couple of times about the idea of the hub of the community and that, from your point of view, is really what Our Place at Doveton is, that the school is the hub of the community?
A. Yes, it is the hub of the community. It is the place where people have confidence and feel that they can cross the threshold into a school, and not only a school but all those things that are added onto the school.

If you think about this: the school is the first thing to open in a community, it is the last thing to close before a community ceases: nothing else. They don't put a police station there first, a school will open, and in that sense that's why it's the most important thing. It is the common thing for everyone within a community. Sooner or later, if they've got kids, will go to school somewhere and it's in that community that we've then built these other allied health and add-ons, if you like.

Q. I'm going to ask now for a video to be played and I'll ask you some questions arising from that.
[WIT.0003.0008.2000]

(Video played.)

And so, that video was really a day in the life of the school?
A. Yes.

Q. I've just got a slide up now and I just want to ask

you about this. [WIT.0003.0008.1000] This is the essential core principles for the operation of the school. I want to ask you about them, perhaps working clockwise from "A Single Entrance". You've already spoken about that in terms of the way it welcomes people in?
A. Yes, absolutely, that's soft entry, that really welcoming entry.

Q. What about, moving on from that, "One Story, One Time"?
A. One of the greatest barriers for any parents who have come through, certainly trauma, is that they are asked to tell their story, repeat their story over and over again to different organisations, different services, and ultimately they get sick of it. And so, as a college, as a community hub, we've basically taken on the idea that we never turn a person away, we'll always make sure that they can enrol at that time, or there's an appropriate time where we're both happy for that to occur.

But at that enrolment for instance, it's not just one person, we bring in our wellbeing team, we bring in all our service team to make sure we have covered all elements so you don't need to go back for another enrolment, and another enrolment.

But we ask the question to the family enrolling, you've got the young people there, okay, that's a school, because they think they're enrolling at a school. By the time they've walked out, often mum's enrolled in adult learning or sewing class or play group, the youngest ones may have enrolled in Early Learning, we may have got them into some of the other services if they indicate that they need those. So, it is that One Story, One Time, it is the idea that the community team is such an important one to ensure that they feel comfortable and they've got a link back to the school, that critical person that they know and feel comfortable coming to talk to.

Q. Moving on then, what about: "High Quality, Explicit Teaching - Birth Onwards."

A. If you look at the results at Doveton back in 2012-2013 when it first opening, nearly 50 per cent of kids in the Naplan testing were so far behind. Young people, education is their key to be able to move into something better in life, otherwise we've just got generational

poverty over and over again.

And so, we can't compromise on the quality of what they're given. In that video you would have seen high quality everything going on. One of the parameters we set up was that we cannot default to second best, because they're used to second best, and that's not good enough. And so, aspirations have to be built, and young people's aspirations are based on what happens in school, the environment they work in and the quality of what they're given, and the most important person in that quality is the teacher.

So, in the first part we had to turn over a lot of teachers until we've got a teaching base that I think is fundamentally as strong as we could have at Doveton, absolutely outstanding teachers and the leadership there at the present time, outstanding.

Q. There's also a focus on quality in infrastructure?
A. Infrastructure. It's quality everything. So, it's the quality in terms of relationships, the infrastructure, the pedagogy that we use, the resources we build into the young people, the programs that we set up and the opportunities that are given to not only the young people but their whole family.

Q. Moving on then to referrals. You say here that, warm and formal to integrated health services?
A. So, if a barrier to entry - and I'll use my economics background here - a barrier to entry is basically an ability to access a service, and that service says you have to book online, but I don't have a computer at home - there's a barrier. Or I have to speak English because they won't understand my language - there's another barrier. Or I have to get into a car and travel but I haven't got a car, therefore I have to use public transport. Those are all barriers. One of the things we looked at was how do we break down those barriers to ensure, if you like, an immediate access to services.

To give you an example, in Play Group, which is a big open area, probably as big as this, just a bit smaller than this environment we're in, we might have 30 to 40 families in there, and if we identified through the paediatrician coming across there's an issue, we don't say to the parent, come back in two weeks and get a booking; we say, come

across and talk to the Maternal and Child Nurse, come across and talk to the allied health. We may have to come back a bit later but you'll have met hem.

So, soft referrals is building that confidence in people to know that they're going to get an outcome in a timeframe that they're really comfortable with.

Q. You've already touched on adult education but you also refer to the volunteer program in these essential core principles?
A. Yeah, so the adult learning is essential. We know that mums are the greatest drivers of educational opportunities for young people. I wish it was dads, I wish I could say that. But mums are the ones predominantly in the care of the young people, and in our case, because there are a lot of single parents, they're predominantly mums. So, we saw that, if we can upskill the parent body in both formal and informal education, they see education therefore as important: if I'm doing it, their kids are going to be doing it.

One of our great success stories, multiple success stories, is a parent who now works at the college, and when she saw this, she had left school I think at the end of Year 9, had a young one there, and she would say she had a pretty traumatic background. She was quite cynical at the start about the whole thing, but she did a short course, Creating Capable Leaders it was called. She did that, a bit cynical, but our engagement team sat down and worked with her.

She then went on to School Council President, did her course, did a Certificate III, is now working at the school in a caring role in the classroom. So things like that just make a huge difference. As she said, I'm studying at home, and her daughter, who's at school, is a ripper, she sits beside her, she's told, get on with your reading, get on with your homework. That wouldn't have happened in the past.

So by being able to get the parents to break down the barrier of education so they see it as important, then it flows through to the young people.

Q. Just in terms of partnerships, you've mentioned health services, but there's also community, government,

philanthropy?
A. Yes, so for instance the City of Casey's involved, we're in the City of Casey, they provide the Maternal and Child Health. Just about all the different aspects are third party providers, we don't run much ourselves. So, the City of Casey provides Maternal and Child Health, Monash Health provides all the allied health and the paediatric Fellows. Then you've got Men of Doveton, Women of Doveton is provided by the YMCA. So, we work in partnerships. We facilitate, we get the clients, and they provide the service, so there is really limited cost to the school, except facilities and the time to get the people involved, and that's where the community team is such an important team.

The Neighbourhood House provides a lot of the funding for the adult learning, and we provide an RTO as a third party, BRACE, who come in and deliver. There's a small amount that comes back into the school, we put that into a person who's basically a childcare worker for the day, because our Afghani mums who want to learn English won't leave their kids anywhere. So, they come in, they have them in the classroom with them but a person looks after them.

Q. You've already talked about the extended day in terms of after school activities, are there other aspects to that extended day?
A. Yes, there is. You would have seen at the start the basketball program. Our young indigenous - we've got about between 7-10 per cent Aboriginal and Torres Strait Islander community, some of the most fantastic kids I've ever come across, but huge trauma in that community as well.

In that community, we saw in about 2016 absenteeism was massive. And so I talked to the person who runs the Doveton Gathering Place, which is the Aboriginal Gathering Place, Emma Thomas, and I said what can we do? She said we need to find a way of getting these kids there. And I said, "I know sport's the driver." She said, "Okay, I'll organise it, you find the facility."

So, at 6.30 in the morning, 7 o'clock, they start. We see our young Aboriginal people either being picked up or running to the college to participate in basketball, and it's got so big they've actually outgrown it, they're going elsewhere to a bigger setting, but the kids are at school.

They can't be in the program unless they're at school, and our attendance of our young indigenous Aboriginal and Torres Strait Islanders would be at normal levels, which is fantastic.

And the other one is the end of the day where I've got our Men of Doveton and our Women of Doveton. The Men of Doveton - interestingly, men don't have great relationships, they just don't have many friends. We opened this up through - we were getting word that a lot of the community, men were just sitting at home if they were unemployed, or had mental health issues or alcohol, whatever it was.

Through the YMCA coming on board and through the other services who had identified young men from the age of 18 right through, we set this program up. The first had 18 graduates. It is basically a 12-week program and is based on the idea of the Sons of the West in Footscray, the Western Bulldogs, who had set up a similar thing, and theirs is massive. But it's all built around resilience and it's built around the idea of building partnerships and relationships, and these people are still in touch with each other. Many of them have now come back to be the mentors for the other groups going through.

Q. And that's not just parents, that's any members of the community?
A. Any member of the community. And any member of the community can use Doveton, so for instance the allied health, Play Groups, et cetera.

Q. If we can just move to some of the key challenges that are faced by Doveton College in delivering Our Place. One of the things you mention in your statement is institutional challenges.
A. Yeah, institutional challenges in the sense of, we set up our institutions primarily for, I suppose, middle-class people, and people who have confidence. So, myself, there's no issue with services provided, I'm happy to get on websites, myGov, whatever it is, but if you don't have a computer, that's a real issue. And many of our parents - only 70 per cent of our parents had access to a computer; they had phones but that was it.

It's also the idea that the services often have a time delay, you have to book in, you have to stay online, all

these sort of things, and those institutional things basically took away from what we were trying to do because what they did was put up a barrier in many cases.

So we had to find a way through that, and the way through that was often to start talking about having soft referrals, having things on site so we could do that. Or more so if our engagement team at the college saw that there was a need to go outside, were able to build the confidence and even take people to those settings so they had confidence, knew where to find them, and then from there were able to make their own way later on. We're not about - it's not a deficit model, it's a model of saying, build the capacity and then they'll look after themselves, they'll make great decisions.

Q. I asked you earlier about the Berry Street Education Model, can I ask you some specific questions about that now. Just first of all, what is it?
A. Berry Street Education Model is a model around social, emotional competencies, but it's really developing the understanding for teachers around trauma-enforced practice, and it comes out of the work of the Berry Street Institute based on some of the work in the US and has been transformed into an Australian model.

So, it's really built around a number of different aspects of what we do in the classroom; it is not something that stands alone, it's everyday elements that we build in around our language, our routines, the way we understand young people, and the way we implement processes and practices to support those people.

Q. You say in your statement that it was adopted at Doveton College because we saw the need for our teachers to be equipped to respond to the needs of children who had experienced trauma?
A. Absolutely. I'll give you one example. If a young person's come through domestic violence, and like any community issue we have that at Doveton. The young person's been yelled at all their life, they've seen physical violence, and yet, many of our teachers who have come from backgrounds in middle-class areas, they thought if they raised their voice that was going to solve the problem. Well, it didn't, because our young people either fight or flight.

And so, Berry Street provided us with an opportunity to understand how you would work through a process of engaging those young people, but also the language you would use and the processes you would use. It is not about the young person per se, it is about their actions. It is not about what they said, it is about the processes that have been put in place to support them.

The one thing we've learnt at Doveton, like any school, is that young people seek to have regularity, they want processes, they want procedures, they want understanding. They want to know where the boundaries are, and Berry Street just gave us another level of boundaries and also processes in terms of that language and processes and procedures.

Q. One of the things you mentioned in your statement is:

> "It's about teachers developing understanding and having empathy for children's experience of trauma and providing teachers with strategies for implementing a positive road forward."

A. Yes, absolutely it is, and it's been a huge change in the culture and the climate of the classroom that we see. And so, you don't teach Berry Street as such, you embed Berry Street into your teaching.

Q. Can you give some examples of how that might be embedded?

A. Okay. So, consistency of language, for instance. We would talk to the young people about "tracking the speaker". So, whoever that is, we want your eyes on me as the teacher because I'm going to talk about, you know, in an explicit way something. Not different teachers trying to get attention in different ways, so we have that common language.

It is about the routines of lining up outside and moving into the classroom, how you would set those up. It is about the thing of positive regard for the young person. What they've done in Berry Street is given us a language and a process, what we would say is just great common sense. Great common sense, but common sense is a rare commodity in a whole lot of things in society. So, by using this we've been able to provide a consistency of

approach across our college.

Q. In terms of the education that staff need or teachers need to implement it, it's initially four days of training?
A. Yes, four days training from the Berry Street team, so that was four came out for four days and we did that across a year. So, that was late 2015 into 2016. And then we have, if you like, a Berry Street mentor, a teacher, who basically was in charge of Berry Street ensuring the continuing implementation of professional development of staff.

Remember, every staff member who comes into the school who's new has to be upskilled in Berry Street. Because, in a school like Doveton you don't bring your own approach to something, there is a really clear instructional model and also a social and emotional model, i.e. the Berry Street.

Q. So, you just mentioned there, it's not just teachers it's the entire staff?
A. Yes, we've got nearly as many what we call ES, Education Support workers, as we have teachers. So, there are about 32, I think, Education Support workers at the college, and again they have to be upskilled in Berry Street because they're working with the young people one-on-one, so that's really important.

Q. In addition, something you say in your statement:

"In addition to the participation of teachers, there is communication with parents about what the Berry Street Educational Model involves."

Can you just elaborate on that?
A. For instance, College Council for a start has had a full induction into Berry Street and then we've run sessions for parents as well in terms of the approaches we use. Because we know, if you have the approach at school and the approach at home, there's so much more in terms of the outcomes you'll get from young people. So, parents have had that opportunity to participate in those sessions.

Q. You've talked about it broadly in a teaching model or an embedding model. Is there any kind of individualisation for students in the way that things might be approached?
A. Oh, absolutely. Because one of the things would be

that you would have to understand where that young person's coming from and what stage they're at. One of the great things - teachers have approximately 25 young people in front of them every day. Those young people walk through the door with different levels of baggage every day, we don't know what's happened at night.

We say we're the most important person in their life because we have them for about seven hours a day and often they see us more than their parents. But at the same time we have to understand what's going on outside, so what are they walking in with? So as a result, we have to differentiate the way we work with young people. Everything can't be as consistent and rigid, but you want a consistency of approach, if you like; within that you've got differentiation.

Q. One of the things you mention in your statement is that students have focus plans?
A. Yeah, focus plans, what they're working on in their own development. It's like an individual learning plan in, say, their literacy, the same thing with Berry Street: what is the class working on and what is the young person working on.

Q. In your experience, what benefits has that model provided?
A. If you look at the statistics that are coming out from Doveton in terms of engagement, so the Department of Education does a student survey every year. Back in 2013/14, the outcomes across learning confidence, engagement, relationships, all the areas that they test were in the bottom quartile at year, say, 7-9.

By 2017, they were in the top quartile. So, what we're seeing is engaged young people. Our attendance now hits state averages. Now, it wasn't that, it was mid-80s, so we're at about 92, 93 per cent, slightly lower in one area, but slightly higher in the other. They're just fantastic outcomes. You can't have young people developing if they're not at school, so in that sense school becomes the consistent, and then what we're doing in the school becomes the icing on the cake, it really does.

MS COGHLAN: Thank you, Mr McMahon. Chair, do the Commissioners have any questions?

CHAIR: Dr Cockram.

COMMISSIONER COCKRAM: Q. Thank you for the really interesting work that's being undertaken. In the last, particularly yesterday, we heard a lot about the importance of communication with families and individuals, and particularly around language. I think you mentioned there's 52?
A. Every day changes, yes, but a significant number, yeah.

Q. How to you manage the language issues both within the school and within the hub?
A. Okay. A great question, because effectively that was one of the barriers. For instance, front desk: Lima, who's one of my receptionists; seven languages, all the Afghani, Middle Eastern languages, and a significant number of our people are from that background, so automatically where do they head as soon as they walk in? Over to Lima.

As well as that, what we did was, we directly employed people from cultural diverse backgrounds, but they had to be good. And so, we've gone out and employed people from different areas based on the idea that they bring, not only quality in their teaching or their support, but language, cultural understanding and sensitivity and so forth.

And so, across the college we would cover, probably out of the 50 different nationalities, we would cover most of those in terms of language somewhere on site.

Q. If I can just extend that question. So, if a family is in the hub having some parenting sessions or seeing someone, would the interpreter come from out of the workforce within the school, or would you bring in interpreters?
A. Depends. Depends if we've got that on site. If we've got that on site we'll go and get those people straight away. To give you an example: one of the great barriers was parent-teacher night. We've all been to parent-teacher night, we've all loved them where you get five minutes of hearing about your young person.

What we've done is, we've got two nights: one for whose English is their first language, and the second night is for those who need interpreters, Because we found out that parents weren't turning up if they couldn't

understand, and rightly so. What we did is, we have a process there. So we get the interpreters in on our, what's called our Cases system, which is our database, we identified those who don't have English as a first language. They ring home to say, "Parent-teacher night is coming up. We will be there, would you like an interview?" Of course, what you've done straight away is broken down the issue of confidence and language and access, and ultimately what we've now got, from very few coming, we're at 80 or 90 per cent of those parents coming.

COMMISSIONER COCKRAM: Thank you very much.

CHAIR: Q. Thank you, Mr McMahon, for your comprehensive statement and for your evidence today. Can I just ask, and for those children or young person or the families where you have concerns about their mental health and wellbeing, how does the service respond to those concerns?
A. Okay, so the first thing is identifying what that is, and that can be quite obvious or become lack of being obvious. We've got an exceptional wellbeing team, and they will meet in a whole lot of different ways.

So, to give you an example: what we've done there is, Amara Miles who leads that, we have referrals into that group, they meet on a regular basis, they will look at all the young people and then they'll work out an action plan: is that something we can internally deal with or is it something we have to go outside to? We have all those different services that we can access. So, that is all done through that team.

One of the other things we've brought in is case management, and so, for instance we will on - might be a Wednesday morning now - the team, let's say it's a Grade 3, they will pick out three or four young people who we've got concerns about: might be cognitive, might be social, emotional, whatever - and they will - 15 minutes we really target those young people and say, what's the issue, what do we need to do about it, what are the outcomes we're looking for? And so that becomes an action plan.

So, those things have been put in place to support the work of the teachers in the classroom. Because, while we're good as teachers in terms of our development of content and processes, we weren't trained significantly in social and emotional, we just weren't trained in it, and

especially a secondary teacher like myself from economics - woeful. But in that sense that's why the support around us is so important, we need to know what we need to do.

Q. And so, that leads us to, and what happens for the young people transitioning out of your school, because I understand that you finish at Year 9, so the children and young people and their families have been very nurtured in the model that you've talked about. We've heard a lot about transitions from one part of the service system to another, how do you manage that and are the attendance rates and participation, for example, maintained to your knowledge when they transition?

A. Okay. So, transition, we've got a number of points of transition: one is from Early Learning into the school, one is from the school at Grade 6 into Year 7, and the other one is from Year 9 through to what we call Year 10, 11, 12.

The Early Learning transition is really important and that's where the team of Early Learning and the school work together. I mean, our young people at Early Learning know the school backwards, they're in there every day, they're part of our assembly so that's not a huge issue. Joining the pedagogy is a challenge at the moment, because you go from a play-based to a far more explicit, but we're working on that.

What we have to do at Year 6 is to ensure that the young people want to stay at Doveton because they have to make a decision to transfer to a senior setting at some stage, that's either at the end of grade 6 or the end of Year 9, and so we've worked really hard on that, that's why the after school programs and everything have been so successful in supporting the young people, and we not only hold them now, we add.

Then at Year 9 the issues becomes, where do you go next? Building aspirations, and while we've supporting these young people we've also challenged them, challenged them to have high aspirations. They don't want to be lawyers and doctors, we know that that's not going to occur.

Our local schools that are 10, 11, 12, we've only got one of those, that's Hallam; that's where I've gone to try and re-shape that so my young people from Doveton have as good an outcome they can have in that senior part of the

school, so there's a bit of work to do there, but we're working on it.

CHAIR: Thank you very much.

MS COGHLAN: Thank you, Chair, may Mr McMahon be excused?

CHAIR: Yes, thank you for your evidence, Mr McMahon.

<**THE WITNESS WITHDREW**

MS NICHOLS: Commissioners, the next witness is Emma King, I call her now.

<**EMMA JANE KING, affirmed and examined: [10.56am]**

MS NICHOLS: Q. Ms King, are you the Chief Executive Officer of the Victorian Council of Social Services?
A. Yes, I am.

Q. Are you also the Chair of the Future Social Service Institute and an Associate of the School of Global Urban and Social Studies at RMIT?
A. Yes, that's correct.

Q. With the assistance of the Royal Commission, have you prepared a witness statement about the questions we've asked you to address?
A. That's correct.

Q. I tender the statement. [WIT.0001.0061.0001]
Ms King, can I ask you firstly to tell the Commissioners briefly about what the Victorian Council Of Social Services, or VCOSS, is and what are its aims?
A. Thank you. VCOSS is a peak body in the community and social service sector. We work to eliminate poverty and disadvantage and to give every Victorian a good life. We do that through our policy and our advocacy work, looking to really influence the way that government develops its policies and shapes its priorities, as I said, with the aim of giving every Victorian a good life.

Q. You're a peak body, so how do the organisations that you represent engage with the mental health system?
A. In terms of being a peak body, we represent a broad raft, our members are a broad raft of the social sector. So, including very small community or volunteer-run

organisations, through to very big organisations such as Anglicare, Berry Street, MacKillop Family Services, et cetera, as well.

We look at the broader ecosystem when it comes to community services, so looking at, for example, neighbourhood houses, looking at justice and legal services, drop-in centres, early childhood services, et cetera, so there's a very broad raft of services that actually make up our broader ecosystem. And basically, wherever you are in a community you'll be able to touch one of those services, so they often have a very strong role in terms of preventing or early intervention in terms of mental health services, as well as more directly engaging in the other side of the mental health system, if you like, as well.

Q. Yes, so a number of the member organisations would engage in the protective factors for mental wellbeing?
A. Very much so. So, if you look, for example, at the community health services, they very much engage in the protective factors - as do the others that I mentioned, looking at neighbourhood houses and others as well - very much in terms of looking at protective factors.

So, if I was to draw on neighbourhood houses as a particular example, looking at one that I'm directly very involved with, whether people come into touch with that local neighbourhood house by virtue of the fact that they have a community garden, that they have a cooking class for people with special needs.

Q. I'll ask you to slow down a little bit. Keep going.
A. So there's many different ways, if you like, that it's kind of a soft entry point for any member of the community to become involved with that neighbourhood house.

Q. I see. In your experience, are there particular parts of the Victorian community who are, by dint of their social and economic circumstances, much more likely to be at risk of developing mental illness?
A. Absolutely. When we look at people who are in poverty, the reality is, they are far more at risk in terms of developing mental health. So, we know overall that at least a third of people who are in poverty have severe mental health issues. I would suggest that that's an underestimate for the reason that they're people who have

been diagnosed.

And we know that, for example, for many people who are in poverty, the ability to be able to access services in the first place is a very significant issue, in terms of being able to literally travel to where you might be able to get a service, having to tell your story multiple times, having an easy entrance into a service, et cetera, is significant.

One of the other things that I would draw attention to there is issues around, for example, housing and homelessness. So we know there's an inextricable link there between poverty and mental health, there's also an inextricable link between housing and homelessness. We have over 82,000 people who are languishing on our public housing waiting list; at least 25,000 of those are children. So, it's impossible to draw out one part of the system without paying attention to another, but we know that, coming back to your initial point, there is an inextricable link between poverty and mental health.

Q. Would you say that disadvantage and mental ill-health reinforce one another?
A. They most certainly do. So, in terms of looking at how any member of our community can look at how they can access general services, so whether that comes to looking at housing, whether it comes to financial assistance, no matter what it may come to, but the reality is, for people who are struggling to get a roof over their head and somewhere that's actually safe, affordable and appropriate to live, whether they're choosing between whether they put food on the table or turn the lights on or turn the heater on in winter or the air conditioner on in summer, they're very real choices that we see people make.

Just to illustrate that point, we saw it was about a month ago I think we had a number of presentations within our hospital system of people presenting with hypothermia, basically because they're old, they're lonely and they're poor. So, they weren't presenting at any other point through or mental health system, but they were presenting in the Emergency Department in our hospital system because they hadn't had assistance along the way, and their defining features were that they were elderly, they were lonely and that they were poor.

Q. What do you say, on the basis of your experience, about the sufficiency of social security payments like the Disability Support Pension and Newstart to help people who may be experiencing mental ill-health to start to reach towards recovery?
A. They're woefully inadequate. The notion that someone can survive on less than $40 a day and be able to meet their living expenses, it's simply not possible. We've seen support for increasing the amount of Newstart come from across the broader political spectrum, and the reality is, if you're poor, if you're trying to survive on less than $40 a day, all of the studies, the Anglicare Rental Affordability study, others show that it's just simply not possible to be able to access appropriate housing throughout the whole of Victoria.

We also know through the poverty atlas research that we undertook and is available on our website, there is not one single corner of Victoria that is untouched by poverty. So, in terms of looking at the inextricable link between poverty, and simply the lack of support that is in place that helps people to access services; that of course goes further than the pure income component alone, it goes to whether you can afford a car or whether you can actually access transport to get from wherever you may happen to live to be able to access services, whether you can afford a phone in the first place.

For any of us who have tried to access NBN or the internet lately, we would know that the only way you can communicate is actually via an online service, so if you don't have one in the first place, your chance of doing that is impossible. What I would say is, even today, walking down to the Royal Commission, we walked past two people who are literally homelessness and in sleeping bags on the street. It's profound and it's staring us in the face.

Q. Can I ask you about the impact of holistic support provided in the community on helping people deal with mental ill-health and move towards recovery. There's an example that you've provided in your witness statement of a young woman called Amy. Would you like to tell the Commissioners about her?
A. Yes. Amy is not her real name. Amy was in a situation of significant family violence and left the relationship with literally the clothes on her back.

Obviously, as a consequence she had no financial support whatsoever, she had suicidal ideation, she was really at the depths of despair, would be how I would describe it.

She approached Star Health, a community health organisation. Star were able to provide significant assistance to Amy. They were able to assist her in connecting up with services that went to looking at housing, connecting up to organisations that could assist her with putting food on the table, with clothing, with a whole lot of other issues as well.

It was that real - the part about actually connecting up and not saying, we're only going to deal with one part of that situation that you're dealing with in isolation, we understand that we actually need to join the dots in looking at how we do that and doing it in a very practical way.

Amy's case is quite profound for the reason that it shows, for someone who was at the absolute depths of despair and her mental health and therefore her physical health, et cetera, was in extreme danger, through the assistance that Star Health provided, not only was Amy able to have some stable accommodation provided and other assistance provided, she was able to then enrol in a law degree at university.

So, she went from a point of absolute despair to being able to achieve something which had been a dream of hers. So, it shows that when we can build partnerships up, et cetera, we can deliver enormous differences for people and look at their broader - not only the living day-to-day, but their broader wellbeing and actually help them achieve the opportunities that they should have and they deserve.

Q. You've said in your witness statement that:

"We need a whole-of-government approach to preventing mental illness and building resilient communities."

What do you mean by that and why do we need it?

A. We've looked very closely at - there's a couple of reasons for that - we've looked very closely at the recent approach that New Zealand has taken in terms of looking at their wellbeing budget. VCOSS advocates very strongly for

Victoria taking the same approach or a similar approach that would be attune to Victoria.

In terms of looking at the five key priorities that New Zealand has and then the 60 indicators, we think we could move quite significantly from our current process of the way that we approach budgets, which are about fundamentally economic inputs, and look very differently in terms of saying, how do we do that in terms of wellbeing? So how do we look at the wellbeing of every single Victorian, how do we deliver on that front?

So, economics is only one part of the job of government, and we know that economics alone doesn't deliver a good life for Victoria. So, for example, at the moment you could argue that Victoria has a very strong economy, but yet you have the parallel of saying, we're in a housing crisis, we've got 82,000 people who are languishing on a public housing waiting list.

So drawing on the model of New Zealand which has prioritised mental health, it's prioritised children in terms of the wellbeing lens that it has as an overlay, along with a host of other things that particularly impact on people in poverty, including looking at the climate, the environment, et cetera, as well.

So I would argue very strongly for moving from the current way that we undertake our budget, to looking at a budget that is a wellbeing budget and having that lens across that more broadly as well.

Q. Is a key element of a wellbeing budget approach to value other things than a purely economic measure of how well society is doing?
A. That's correct, it's about putting people first, and if we've going to look at how we put - in terms of looking at putting a wellbeing budget in place, if we measure outcomes by actually what are the outcomes for people rather than looking at it purely through an economic lens, it's a much - I think it's an eminently sensible way to approach this.

The economic lens - and New Zealand has - there's a lot of commentary around this, around saying that, if you look at it purely from an economic point of view, it doesn't capture the people who are left behind. We know

that there's a significant amount of inequity within our society more generally: it's a really sensible, sound, robust way to say, let's actually look at how we do our budgets and do them differently, rather than through the pure sort of output measures that we look at at the moment.

Q. You've also said in your statement that "place-based responses empower local communities". Can you say what you mean by "place-based responses" and then I'm going to ask you about how they empower communities and why?
A. Certainly. And I feel quite privileged actually to come on after the principal of Doveton Community College and I've had the good fortune to visit there on a number of occasions and they're just outstanding in the work they do and a perfect example of place-based communities, and I know the Commission has visited Maryborough and we've been fortunate to be involved with Go Goldfields along the way as well, and being invited to sit at their tables has been an absolute privilege.

When I talk about place-based there are a number of key indicators that are really important as part of that. One is in terms of being genuinely place-based, so genuinely embedded in community and tailored to the local community however that might be defined, and that will look different in different places. So, it's not taking a cookie-cutter model and looking at one size fits all.

It's having flexible funding so that the local community can determine what are the key elements that they want to change within their local community, and Go Goldfields is a perfect example of that, where they looked at the key indicators that they wanted to shift in their local community but having an evaluation process in place.

Q. I'll ask you about Go Goldfields in a moment, but getting to flexible funding, in what respect does it have to be flexible?
A. It needs to be flexible for the reason that, if you can look at what the key indicators are that you want to change in your local community, quite often funding from departments, to be frank, it can be quite micromanaged and it's designed to deliver a particular outcome or a particular output.

One of the things that we know, and it does stray slightly into Go Goldfields, but we know that they will try

ideas with the very best of intent but sometimes they wouldn't work. So, they need to be able to be flexible to say, we can adapt to the local situation, the local community or the local environment. Part of being flexible is looking at where can we create funding that might come from a range of different sources, how might we be able to combine that to achieve particular outcomes for a community rather than looking at a particular output that might come through one particular department.

Q. I might ask you now to talk about Go Goldfields, firstly by saying what it is?
A. Yes, so, Go Goldfields is a place-based initiative, it's placed in Maryborough. I know the Commission is aware of this having been there this week, equidistant between Ballarat and Bendigo. One of the challenges I think Maryborough has had as a community is in terms of looking at somewhere that - and I want to be careful how I describe this, because in working with local community members, one of the things they talk about is, they don't want to be defined by a deficit model, they don't want to be defined by the disadvantage, even though there's significant disadvantage that exists within the community and it's significantly poor.

They want to look at the strengths that they have in terms of a community and the fact that there's a huge amount of voluntarism for example. There's a huge amount of local leadership.

It's through that local leadership that they were able to define, I think, fundamentally pitch to government a very effective model about the things that they wanted to change within their community. They wanted to reduce the number of children who were referred to child protection, they wanted to increase the literacy and numeracy within their community, they wanted to increase the employment levels within their local community.

They've been able to show on their key indicators, and this is evidence that's been undertaken through Murdoch, that they were able to shift on the key indicators that they all chose. When you go to the local community, irrespective of whether you speak to the maternal and child health nurse, just someone from the police, just someone from the hospital, to the school, to the local business, the president of the football club who

happens to also be the president of Rotary, they can all tell you what they are doing and how does that combine and how does that impact on those indicators, it's incredibly powerful.

One of the other things they do, and an example of this would be in their approach around family violence, when they developed their approach around working to eliminate family violence within their community, they put out a call in the local community to ask women who were victims of family violence to come forward. They had over 30 women in a local community come forward to contribute to that strategy, but one of the deal breakers for them as has been reported to me is that they said, we don't want to be victims, we're experts. And we'll sit around the table and we'll help you work out a strategy going forward.

It was a privilege, I was asked to launch that and to launch their policy, and it was incredibly emotional and really profound to have that at that launch a large number of women who have lived experience of family violence, standing alongside representatives from council, local business, the football club, the school representatives, basically the whole community and it was the whole community's business and that's how you make change.

Q. Do you know how Go Goldfields got started?
A. Go Goldfields got started because they pitched to the government. I think, to be frank, the money was delivered slightly just before an election date, but they pitched basically after quite a lot of community work saying these are the key indicators that we want to change in our community.

When you look at the Dropping Off the Edge report, that Jesuit Social Services drives, Maryborough was always in the top five communities for the wrong reasons: it was always considered a community of abject poverty and disadvantage, but yet you had a local community who said we know this can change, we can take ownership and we can help deliver that change but you have to let us do that at a local community level, rather than having people coming in from outside and imposing ideas that over time were proven to not work.

So it was around saying, look, we've tried a whole lot of other things, but they haven't worked, what can we do,

what can we do that's different?

Q. In relation to the question of funding, can I ask you to say some things about the NDIS. Firstly, in the wake of the NDIS's introduction, what's been your experience about pricing and the barriers it can create to accessing services?
A. Pricing is a significant issue when it comes to the NDIS. So, in terms of looking at the price that is provided to deliver a service, it's significantly beneath the actual cost of providing a service. So, what that means, so I don't think we'll find anyone who's going to argue against choice and control as envisaged within the NDIS. However, there's a perverse sort of thing happening at the same time, where by virtue of providing a funding model that is less than the cost of delivering a service, I would argue that it's not being set up for success.

So there's the issue around price in the first instance. There's the issue around what does that mean for local providers and people who will provide the services for the NDIS, keeping in mind, for want of a better term, it's a growing market.

If you're not providing the price of what it costs to deliver a service, there's a huge challenge about, well, who is going to be present to deliver the service a community needs? So, we're seeing already community service organisations for example, because they simply cannot afford to deliver a service, withdrawing from communities and no longer delivering those services at all.

That has profound impact for people who have disability, who deserve the very best - and I would argue - the NDIS talks about an ordinary life, I think we want people to actually have a great life. It's very hard to have that if the very pricing of NDIS doesn't enable you to get those services in the very first place.

Q. So your concern is about the sustainability of the sector that provides services that the NDIS is intended to fund?
A. That's correct, it is about that. There's a couple of other points I would raise in addition to that. One is, keeping in mind with this being the Royal Commission into Mental Health, that it was never intended by the NDIS to actually cover many people who have mental health issues.

So, it was really, if you look at the forecast, it was about 10 per cent of people who have severe mental health issues that NDIS was set up to service and establish.

So, if we look at people with severe mental health issues, that means there's about 135,000 Victorians who are going to be left behind.

Now, there is some transitional funding that's been provided by the Victorian Government for a two-year period. And when I say 135,000, I'm talking about people with severe mental illness and I'm talking about what I believe is an underestimate, because we know a number of people who have mental health issues are not diagnosed, particularly, as I mentioned earlier, people in poverty who may not be able to access services in the first place.

Then we have a whole group of additional people who don't necessarily meet that severe diagnosis who might have episodic mental illness. The NDIS is not designed for them at all. So, we have a huge gap when it comes to NDIS and mental health services because it is a system that was not really set up to deliver services to people who have mental health issues in the very first place.

Q. Have you had any experiences of any other difficulties that people with severe mental health issues have accessing services?

A. There are a number of issues that people with severe mental health issues do have in accessing services, and in speaking with our member organisations in particular, they will work very hard in terms of having services that are accessible, but acknowledging that for many people being able to access a service in the first place is very difficult because our system is often very much based on a medicalised model when it comes to mental health.

It shouldn't be an either/or proposition, but often for people to be able to access any assistance it's only possible to get that assistance very much at the tertiary end. So, your health has to have deteriorated to such a significant extent before you can get the assistance that you need.

So we know, for example, that half of all people diagnosed with a mental illness, that mental illness has

become apparent by the time a child is 14, and three-quarters before someone is 25 years old. Yet there's been very little investment in prevention, in early intervention, and we've seen the most significant funds going to the tertiary end. And we have heard story after story of people who have sought assistance at the very early stages of a mental illness and yet they've been told they're not eligible until they get to a tertiary point where they actually require significant clinical care.

In terms of, if we're going to re-imagine our mental health system, and we were to look at the broader ecosystem of community-based mental health services and the other ecosystem that exists within our community, I think if we were to look at what we want our system to look like, how do we use all of the components of our community to actually deliver prevention, early intervention, and to help people early rather than saying we're simply not going to give you any support until you get to the tertiary end.

Q. Can I return to a subject you mentioned earlier and that is homelessness. You have proposed that Victoria has a statewide discharge policy requiring no exits into homelessness. Can you explain what you mean by that?
A. Yes. In terms of, we know for example at the moment - as I said, homelessness is really profound when we're in a housing crisis in Victoria - in terms of looking at what we would argue should be a rapid re-housing type model, would be for example if someone's currently in the justice system or they're in hospital or they're in another environment, the reality is a number of people are being - whether it be hospital or justice system for example - they're being discharged into a situation where they actually have nowhere to go.

So, if you're being discharged from a hospital, but you don't have anywhere safe to live afterwards, if you don't have a mental health condition already, you're probably going to develop one fairly quickly.

For people who are exiting our justice system, for example, we know that many people are exiting and they have absolutely nowhere to live; or, if they do, it's really insecure and kind of questionable housing that I suspect none of us would want to live in. So, it's really critical.

Every single committee that I'm on, whether it's looking at mental health, whether it's looking at justice, irrespective of where it is across the broader social spectrum, the first thing people raise is housing, because unless people have somewhere safe, affordable and appropriate to live, the reality is it's going to have a devastating impact on their mental health.

So we believe that it's really important for anyone who, wherever they are in our system, if they're being discharged from a service, et cetera, they need to have somewhere safe, affordable and appropriate to live. It's a bit of a no-brainer, if you don't have somewhere safe to live it's clearly going to have a significant impact on your mental health immediately.

Q. Can you tell the Commissioners something about the Doorways program that helps people find a home in the private rental market?

A. Yes. There's a range of different models that exist that actually look at, when we're looking at broader rapid re-housing and thinking about what are the different models that we can have that exist under that broader barrier. So, in terms of the Doorways program, it exists through Wellways, and I'm aware Wellways has appeared also before the Commission, so I don't want to restate anything they've already spoken about.

It's that strong importance of looking at the wrap-around services that also occur at the same time that someone is being housed, and looking at the interaction with the private rental market and the opportunities that exist there, alongside looking at - so if we're looking at public housing and social housing, but also looking at the way that service providers, and in this case Wellways, work with the private rental market and look to provide support to people who require it in terms of the broad raft of support of people who need it.

But making sure along those lines that we can access the private rental market as well, because if we look at affordable housing overall, it's a key part of our system at the moment. We've got a huge long list when it comes to public housing and when it comes to community housing as well, so we need to look at how we can access our private rental market which at the moment is extremely unaffordable for most people, particularly obviously those who are in

poverty.

Q. One of the things you emphasise in your statement is the need to have integrated and coordinated services about which we've heard quite a great deal in this Commission. The description you use is "partnerships". Is there a way in which competitive tendering has the propensity to undermine productive partnerships?
A. It most certainly does. Competitive tendering we've seen work to the absolute disadvantage of the broader community service system. Many of our services are put out to public tendering. Within that context, a key example would be within the alcohol and drug space, where five years ago there was a significant re-tendering process that took place.

What we found as a consequence of that is, first of all organisations were pitted against one another, so it was the very opposite of requiring people to actually work together to deliver the best possible service for the community. Instead organisations were pitched up against one another to provide the lowest possible cost to deliver a service. What that's meant in real terms is, we know that about 20 per cent less services are now being delivered.

When we look at some of our regional areas, for example, we know that people who are engaged with a service because they had a connection of trust and a connection with their local provider, once a new provider came to town, for want of a better term, the reality is they fell through the gaps and they haven't come back.

So the impact of competitive tendering, not only does it mean that often it's sort of a race to the bottom in terms of looking at the kind of cost: you know, an organisation knows that, if they're going to win, they've got to come in at the lowest possible cost. We need to look at what is that cost to community. So, if an organisation is delivering at the lowest possible cost, then who misses out? Because, if you can't afford to deliver services to all of the people who were previously receiving them, that's a key issue.

In many cases where people have mental health issues, they develop a significant level of trust with a particular organisation, with a particular worker, or a set of key

workers or a case manager. If that person leaves, there's every chance they won't come back. People often have issues in terms of levels of trust when it comes to authority. If you lose those connections for people, the reality is, that often doesn't change.

Q. And so, are you suggesting that the criteria for tenders need to be broader to accommodate the things you've referred to?
A. They really do, because we know that we can achieve the greatest outcome through partnerships. We know, in terms of looking at how - the previous witness spoke about having that common entry point, for example, so people not having to tell their story multiple times: that's a really critical component. Because if you're constantly having to re-prosecute your story, we know that people just give up.

The other part is that there's a barrier after barrier after barrier put in someone's way, so we need to be able to take that away and, if we've got organisations that are competing with each other, we're not enabling the process for partnerships, and strong resilient partnerships that will evolve beyond the relationships someone might have with one key individual as well, but are actually stable and there for the test of time.

Q. Can I ask you about some of the challenges in securing a high quality workforce in the community sector?
A. There's a number of challenges about a high quality workforce within the community sector, and one of the things I would say overarching there is that, keeping in mind that, according to ABS data, this is the fastest growing area of the Australian workforce. So, when we look at healthcare and social assistance, this area is growing faster than any other area of the workforce, so it's important to look at for a number of reasons.

These jobs are generally poorly paid, they're precarious, highly casualised, and they're also highly gendered, so they're generally held by women, and I don't think they're particularly well valued by our community, despite the fact that they provide critical services that deliver the wellbeing of our community.

There's a couple of key points that I would also make in addition to that. One is, when it comes to community sector organisations in Victoria, they're indexed at

2 per cent per year. Now, we know that is below the award cost of providing a worker in that sector. It's also below the cost of providing a service in Victoria. When I mention the cost of indexation, I don't mention it for the point of one year only, this is a compounded effect. So, for year after year after year in Victoria we have had indexation rates that are well below the cost of delivering a service.

One of the challenges we have in that space is the lack of data. So, if I was to contrast that to our health sector. If you were to go to a hospital, it's very easy to get data on the workforce, it's very easy to get a common dataset. You can look at the projections of what that hospital will need, the age of people who are delivering services, et cetera. We don't have that for the community services sector.

To contrast that, in the health sector they receive a much higher level of indexation that actually meets the requirements of delivering the required service. We don't have that in the community sector and instead we have years of very low levels of indexation that don't meet the requirements of actually paying someone their award or agreement wage, let alone delivering the broader service overall, so that's a key challenge that we have.

We also have one additional challenge which is that, because we don't have enough workers in the system, with the recommissioning that occurred, for example, within the alcohol and drug space, we see workers leaving the sector overall. Keeping in mind that, because this is one of the highest growth sectors, there's a high degree of competition between workers who are in the mental health space, workers who are in family violence, the NDIS, early childhood, these are all growing workforces, yet none of them have particularly secure or well paid jobs.

So, there's a lot that can be done. A common dataset I think would help us enormously in terms of having a very strong evidence model around that and looking at how we can look at much more secure funding towards these services into the future, keeping in mind that none of these services are going to be replaced by automation. They are jobs that require people, they're jobs that require people who are highly skilled at their jobs, we need to value them and we need to look at this as a workforce for the future

because that's what it is.

Q. Thank you, Ms King. Are there any matters that you would like to raise that I haven't asked you about?
A. I don't think so, thank you very much.

MS COGHLAN: Chair, do the Commissioners have any questions.

CHAIR: Professor Fels.

COMMISSIONER FELS: Q. Thank you for your evidence. At various points you talked about homelessness and the broader questions of housing and accommodation. I just wonder if you could give us your general take on public housing and mental illness. How do you see the state of public housing and its relationship to accommodation for the mentally ill?
A. I think there's probably a number of different aspects to that. Because I think one of the key parts is accessibility in the first place. I think it's around looking at also the connections that exist between people who live in public house and being able to access services. So it's probably, I'd say, depending on where someone lives, they would have different experiences on that front which could be worthy, I think, of further examination.

One of the challenges we have, though, as I mentioned earlier, is people simply being unable to access public housing, and within that context probably talking more broadly about social housing overall, whether it's public or community housing, and the fact that we have such long waiting lists. And again, when we've got well over 80,000 people on a waiting list for public housing, and 25,000 of those are children, I think those figures are startling and show a housing crisis.

In the last election we saw the Premier announce 1,000 new public houses for this term of government: we would recognise that as down-payment in terms of what's required.

There is a social housing growth fund that the Premier and Treasurer have invested in. I'm very interested to look further about what opportunities are there out of the social housing growth fund. Because the reality of that fund is it was set up so that the income derived from interest from that fund would be delivered straight into

social housing. Now, I've not seen anything come of that yet. I would have an expectation that government would be delivering on that and I imagine it would be an area that the Commission would want to look more further into, because there should be significant opportunities there as well. I'm not sure if I've fully answered your question.

COMMISSIONER FELS: No, it was such a general question.

CHAIR: Q. Thank you very much, Ms King. There's one other thing I wanted to ask you about, which is: in the evidence we heard earlier about Doveton College and its success, there was a contribution from a philanthropic organisation, so over and above the contribution of government, the contribution of different agencies, there was a philanthropic organisation, and even in the example you used of Go Goldfields, there was a high level of volunteering and community contribution.

With this focus on place-based innovative models of service design and delivery, how important do you think it is for us to maintain that broader philanthropic volunteer community contribution to service delivery?
A. Certainly. I think volunteerism is really important, it's probably something that we often see quite clearly in place and it becomes to part of belonging in community contribution. I think there are a couple of things at play. Obviously, looking at philanthropic support, that's always going to be incredibly welcome, and what we tend to see is that that allows a higher level of innovation than government funds have traditional enabled.

I do think that there is significant room for government to look more broadly about how might there be more flexibility and trust with the way that community uses funds.

In that example I would go back to Go Goldfields and say they had an evaluation model running throughout, so it's not about saying, you know, here's money with no accountability. We're watching communities - and Doveton is another example - who want to be very accountable for the money that they receive and look at actually how are they measuring results and results of their community along the way.

So I think the philanthropic money has been really

important in enabling innovation in a way that government departments traditionally have not done. I think that there can be more than philanthropy at the table enabling that to happen. I think it's the challenge for government departments where there's often risk involved, and I understand in terms of being risk-averse, but I think that there's better ways that we can fund communities to actually deliver better supports for people, and we've got great models such as Doveton and Go Goldfields to really provide evidence for that.

So we've argued for a social innovation fund that we think could be provided by government to enable communities to try some new things. Particularly when we look at communities that are in, to be frank, abject poverty, that have been for years, I would argue that multiple different approaches have been tried with the very best of intent but they haven't worked, and we've looked at communities that really are ready to go with their own ideas, looking at how they can do things differently.

We know they tend to get those ideas up when they talk to philanthropy who are keen to back them. I think it would be great to see government step up more to the plate as well to say, well, actually what role can they play without putting in - often they'll seek to put in overarching backbone support from outside a local community, which seems to me to defeat the purpose a bit.

Q. We've also heard throughout this Royal Commission and at various times about the importance to break down social isolation for people with mental health issues, and there's often been commentary about the fact that now we no longer have drop-in centres or day centres, and some of the psychosocial supports that have been available in the past seem to be diminishing. What is your reflection on that?
A. My reflection on that would probably go to some of the comments I made earlier in terms of NDIS and other services, where we've seen organisations, if you like, that are not adequately funded to be able to provide the services that they want to within local communities.

Another example would be looking at aged care, for example, where previously organisations that received block funding were able to spend more time with people who might be lonely and in their homes; the fact that they had more time to be able to spend with someone, to help them shower,

to help them do other things as well. And we know that now those services are being cut back, so we're seeing significant cutbacks being experienced across the board.

And, when it comes to - if I go back to where I opened which was looking at neighbourhood houses as an example: they're a beautiful example, I think, of where people can come together without having to disclose mental health or loneliness or all those sorts of things, because they're a sort of a soft entry point where you might go to be part of a community garden or a choir or a cooking class and actually become part of your community.

So I think we really need to look at how do we invest in our community, how do we invest in our broader community ecosystem, because we know that, in doing that, that actually deals with many of the issues we have around isolation and loneliness.

In that example there is something key in mind for me, and that is that at our local community neighbourhood house, there is a gentleman who has schizophrenia, he is regularly in and out of hospital but as soon as he's discharged he comes into the neighbourhood house because that's where he belongs. Everyone knows him, and we know him very well, and he's a key part of the neighbourhood house and his background was as a barista. Some days he comes in and makes coffee for everyone. But it's the place that he belongs and, as he describes, the neighbourhood house saved his life.

COMMISSIONER COCKRAM: Q. You mentioned in your statement about partnerships and we've discussed that a little bit, but we've also heard throughout these hearings consultations from Community Primary Care and a range of people about the complexity in the number of people in the NGO mental health space, if I could put it that way.

Has VCOSS got a way forward in relation to the complexity of that service provision system? And, have you got some suggestions for us to consider as part of that?
A. That's a great question. I think part of that also comes down to the contracting or tendering out that's taken place that's probably splintered the system to a degree as well, so I think if we can look more at that partnership model to begin, but also take the broader view around - I do think there's that ecosystem that exists in terms of the

community, because really, wherever someone enters, it shouldn't mean that they're having to tell their story again and again. So, whether you enter through a community health service or whether you enter through a neighbourhood house, et cetera, I think there are some things we can look at there in terms of where are the referral points, where are the caseworkers that help people navigate through a system, but looking at embedding a system that's about partnerships and developing and delivering partnerships rather than a competitive model.

I think that one of the key parts around sometimes looking at local community or place-based models, they're often very good at working through that themselves where they're genuinely and able to be place-based models, and if you look at Doveton for example and all of the services that are delivered not necessarily through Doveton but, as they talked about with the partnerships they have with other - whether it be local council, whether it be health organisations, whether it be others - for the person who's coming in accessing those services, the point is that they're there rather than who are they accessing them from.

If you look at Go Goldfields and how they provide services within the local community, the point is that those services are there. I remember hearing one of the local Maternal and Child Health nurses speaking to the librarian around talking about encouraging a young mum to take her kids to story time, and this mum, this is her third child and she'd not been to story time beforehand. So, thinking around actually how do we have conversations with people about the services that exist for them, but how do we try and join that up as a system rather than make each an individual part and harder for people to navigate. Because the reality at the moment is it's a system - loosely termed "a system" - that is incredibly hard for people to navigate and, to be frank, incredibly hard at times to access.

I'm not sure if that, again, fully answered your question.

Q. I guess the question has at its base, have we got too many of these multiple agencies out there? And I guess it's certainly making it hard for both - it sounds like in the evidence we've heard - for GPs, for consumers, for their families, about which one's delivering which bit, and

I just guess I was asking if you've got thoughts on that? A. I think some of that comes to clarity as well. So, one of the things that strikes me is, for example, if someone goes to visit their GP, does their GP have the information at hand about what other local services are on offer, and I would expect in many cases they simply don't.

We know for example, looking at the energy space which VCOSS has done a lot of work in, often the first place people will present will be at their GP. But we know GPs don't necessarily go through and say to someone: actually, the reason you're presenting with a particular illness is because you can't turn the heater on and you're cold and there's a whole lot of other issues here.

So having a GP equipped to talk about, here are the other local services that we can connect you up with, how can we help you. Those sorts of things I think are really pivotal. So, part of it is about information and looking at, in a local area, actually how might you bring that together so again it's easier to navigate.

I do think Doveton is a perfect example of that, where it's actually looking at, not only the child, if you like, that enters the Early Learning Centre or the school, but actually the whole family, and it's a perfect example of a place-based model that is really there to help people but also might identify things that someone may not identify in and of themselves, but to say, we've got this other service. Again, it's that "how can I help you" approach that means that people might be willing also to disclose things that they may not feel free to disclose to people otherwise.

COMMISSIONER COCKRAM: Thank you.

MS NICHOLS: May Ms King be excused, Commissioner?

CHAIR: Thank you very much. Thank you for your evidence today.

MS NICHOLS: Chair, is it convenient to take a 15 minute break?

CHAIR: Yes, thank you.

SHORT ADJOURNMENT

MS COGHLAN: The next witness to be called is Matiu Bush, and I call him now.

<**MATIU ROGER BUSH, affirmed and examined: [12.06pm]**

MS COGHLAN: Q. Mr Bush, you've provided a statement with the assistance of lawyers from the Commission?
A. Correct, yes.

Q. I tender that statement. [WIT.0001.0056.0001] You are the founder of One Good Street?
A. Correct.

Q. Which is a social networking platform to encourage neighbour-initiated care for older residents at risk of social isolation and loneliness?
A. Correct.

Q. What's your other key role at the moment?
A. So, I'm the Deputy Director of the Health Transformation Lab at RMIT University, and that lab is set up to tackle health care's most wicked problems, our thorniest problems, and that includes loneliness and isolation.

Q. When did you start in that position?
A. July the 1st.

Q. What about your broader background; I guess, first of all in relation to having a Masters degree in Public Health?
A. Correct, so a Masters degree in Public Health, a nurse practitioner and have been involved in health care for about 25 years. So, I've had clinical experience in emergency departments, ICU, oncology, outpatient department, elective surgery wait list, so I feel that I have a broad lens or a broad view on the health care system.

Q. Can I just ask you a bit more about One Good Street. Can you tell the Commissioners what that is?
A. Absolutely. So, One Good Street's a network or a platform that exists to reduce isolation and loneliness in older people. The idea came about when I was helping out an elder gentleman on my street, and he would fall out of bed and I would go and pick him up and put him back into

bed. I also am on the Board of Medicare Victoria, so I can see from the vantage point of the entire health care system about how to save money, and I knew that my act of neighbour-initiated care of putting this gentleman back to bed was saving an ambulance trip, an ED presentation.

And when I started to talk to people about this, they were saying, we do the same sorts of things, there's an Italian Nonna that we look after, there's somebody else that we look after. And so I saw this almost tapestry or safety net of neighbours who are doing so much in the care space and do so freely, and it adds value to them and adds value to the community but it also adds value to the front door of the Emergency Department.

So I designed One Good Street which was to develop a participation culture within suburbs to make it really easy for people to do great things for their neighbours, and we link that to a map on our website which accredits those streets, so streets change colour if you're a member of One Good Street.

That idea and that innovation came from listening to an auctioneer talk about the importance of social capital and why you want to buy a house in this suburb, because this is a thick market of social activity, there's lots of social capital.

So I saw that we needed to reward streets for this work. It's a channel, there's 730 members at the moment, we are live in four suburbs. We run a range of initiatives, but essentially if you're an older person and need help you can reach out to that network and there are plenty of people who will jump in.

We see people through the lens of neighbours, rather than through NDIS, through other diagnostics or through other funding sources.

Q. Can I take you back to ask you some more broad questions about community resilience and connectedness. So, in particular, from your perspective how does loneliness impact on the mental health of individuals?
A. It can be a predecessor or come afterwards. It's actually linked very much into chronic illness. So, when you are experiencing a chronic illness of any description, both physical and mental, loneliness and social isolation

may come after that, which then compounds the symptoms. It all may exist beforehand through circumstances in your life such as loss of partner or a range of things such as geographic isolation from others, so it precedes the expression of anxiety and depression and there's good research to show it's very much linked to anxiety and depression.

One thing we notice, and I think this is key, is that when we do initiatives or roll out initiatives to address isolation and loneliness, people's health gets better, people's mental health gets better.

There's an example in the submission by Judy Lowthian at the Bolton Clarke Institute Research Institute, where the project was to call older people over 75 years of age once they were discharged from hospital and phone them every week to check in on how they're going.
60-plus per cent reduction in depressive symptoms: the answers are there.

Q. Just leaving One Good Street to one side, what is the role for technology in reducing social isolation?
A. Technology definitely plays a role, but it is never separated from the tactile. So, the digital and tactile need to go hand-in-hand, so face-to-face services as well as the latest technology, and we're lucky enough in Melbourne we have a thriving start-up system, we have a thriving social impact entrepreneurial system to draw from. There is a huge design community as well that is intently interested in doing work for meaning.

So, there's a group called Designing for Health with 140-plus designers who want to design in health care, and so, at this point in time in Victoria, we've got this confluence of activity that can deliver great technical advantages, and homegrown solutions are there.

I'll just talk you through very quickly a few. One of them is called Sofihub, which is artificial intelligence in the home, and that's a voice that talks to you, it's about the size of a drink bottle, and it reminds you to take your medication, it reminds you the temperature of the day, and older people who have this technology in their home, they talk about it as being like a guardian angel presence because someone's there talking and reminding them of things.

There's another one called Umps Health, which is really all developed here in Melbourne or Victoria, where there is very, very non-invasive sensoring in the house: so plug, kettle, fridge, TV, microwave, and it builds up a pattern of normal activity, and if there's a deviation from that normal activity it sends an SMS to family, friends, health care services to say, at 8 o'clock this normally happens, this hasn't happened today. And that has real benefit because, if you've fallen over in your house, then you're only lying down for an hour before someone gets a message, compared to 8 hours, compared to 12 hours. And that's saving a lot of money for the health sector.

My Lumin is a brilliant easy tablet for older people to have connections with their loved ones. And there's something called Gabrielle Cares which is a beautiful little robot that follows older people around in their home. It detects falls, it can sense pain, it communicates to others, and this technology doesn't require a tremendous amount of upskilling of the older person, it happens seamlessly.

So, technology can alert the rest of the community, what I call a person's ecosystem, which is everything in their life, that something may have changed. And we'll talk later about CaT Pin which was developed here in Melbourne as well.

Q. Those technological advances that you've described, how do they then mesh with the tactile, which you've said is also essential?
A. Absolutely. So, the technology in somebody's home or what they are wearing should be alerting somebody to do something, and there is machine learning and algorithms behind that which is absolutely part of the solution. So, it is a false dichotomy to think of it as all face-to-face and no tech or somehow demonise tech. It is both simultaneously improving their lives to help people not just survive but thrive and flourish.

It is what that tech does with that information, that data, and then who it reaches out to. For something like One Good Street, it could reach out to One Good Street and neighbours could go and check on somebody if they hadn't been seen for a while or didn't turn up for an appointment, so that's where that tactile comes in: it meets an

interface where humans then respond.

Q. You mentioned before the CaT Pin. That's a creation of yours?
A. Yes.

Q. Can you just describe what that is?
A. So, CaT Pin is a wearable that detects loneliness. I'd been visiting with community nurses, the Bolton Clarke community nurses, and I had visited a woman who was 101, and we were the only people who visited her that day, and it was her birthday. And I left that house thinking about the poverty of conversation of her experience at 101. And then the very rich conversational life that I have, online virtual, as well as face-to-face, and really there's such a thin market of activity and there's such a thick market in my life and a very thin one in hers.

And I thought about, could word count be the surrogate marker for a poverty of conversation which is linked to isolation and loneliness? And at the moment we've got nothing in real-time to tell us whether someone is isolated or lonely. So, I took that concept to RMIT University, and the School of Design helped develop a prototype and then we continued to collaborate with different parts of RMIT University to develop a prototype that counts the number of words older people speak. Thresholds are set, so if you drop between a particular threshold, it sends an SMS alert to family, friends or neighbours to give you a phone call. It interacts also with the ecosystem that's funded by the government which includes home visitor schemes, telephone support from Red Cross and Friends For Good; all of that ecosystem's there, this just joins it all together in a real-time response to isolation and loneliness.

We also look at what are the intrinsic things that older person can do to increase the word count, and also what extrinsic resources are already available. You and I speak 20,000 to 30,000 words a day. Somebody who lives alone, we don't know how much they speak. We don't know what Australia's loneliest day is, so for people in the community, that's never been researched before.

So the CaT Pin is like a trojan horse that opens up all the possibilities of research of what is Australia's loneliest day? How many words do people who have no-one in their lives speak? Who are the people they do speak to?

The post person, newsagents, whoever, the community nurses, care workers. Then that helps us to understand the interventions and the people we should be intervening with.

It also helps target the interventions and isolation of loneliness. So that, if Tuesday and Wednesday is the day when most people who live alone with no-one in their lives don't say anything to anyone, then what resilience do we need to build in on Monday, what type of activities best reduce people's burden of isolation and loneliness.

This is important because you're at 26 per cent increased risk of mortality if you're chronically isolated and lonely, and you also use services more. So, something around 60 to 66 per cent increase in GP visits, in Emergency Department presentations.

When I worked in Emergency, there was something we called the positive suitcase sign. So, if an older person turned up with their suitcase, we knew it was a social admission. So, that gives you an idea of the impact of loneliness in our tertiary healthcare system.

There are people that cannot be discharged from hospital because there is no-one to discharge them to. There's a home, but there's no food in that home, there's no support in that home post their discharge. We want to take what being discharged to the community could truly mean with a different type of ecosystem surrounding that individual.

Q. You've used the word "ecosystem" a few times and you did explain it briefly earlier, but could really articulate what you mean by that?
A. Absolutely. So, to give you an example, it is everything in somebody's life, all the touch points in their life. So, for many of us here today we may have bought a coffee from some place, we may have had a conversation, we may have gone to the newsagent before we came here, they're all the - it's almost like the choreography of your life and all the people you touch along the way, all the resources and the systems and services you interact with: that's somebody's ecosystem. By respecting that ecosystem, that's where new technology and startups can come in and then start to transform that ecosystem, and potentially reorganise the resources that are already there.

Because in our communities there are tremendous local heroes doing great things, and a re-organisation of that towards somebody who's isolated and lonely is incredibly cost-effective, but it's also incredibly powerful for that individual and for the community.

Q. You talked about before the potential uses for the CaT Pin in terms of research and understanding of loneliness. Has that progressed to that point yet, or is that sort of in the ideas phase?
A. So, we have a prototype at the moment and we are working with funders to build up a program of work, to turn that into a prototype. We engaged with jewellery designers so that we could design something that was very desirable to wear and that's incredibly important in that co-design piece with older people. Because many older people won't wear technology if they see no benefit, but also when we talk to older people they don't like the disability beige that everything comes in. That's something Leah Heiss always talks about, that disability beige.

We offer no purposeful design to make something that is about disability into something that's desirable to wear. So, we're at the early stages of it. Telstra Health awarded us $10,000 to start that work.

Q. Can I just ask for the "CaT Pin in Action" to be put up? [WIT.0001.0056.0024] It's a bit difficult to read, you might need to talk us through that?
A. Absolutely. We would like this to be socially prescribed by a health professional.

Q. What do you mean by that?
A. So social prescription is when any clinician prescribes to you an activity or an action based on agreed goals. So, if you said to me that, "I would like to exercise more because I've got blood pressure or for managing my anxiety", then I would write you a prescription to the local exercise club or the local walking club or the local garden club, and then we would check in on that to see how that's tracking for you and whether it was achieving the goals of reducing your blood pressure, helping you do more exercise, reducing your medication, et cetera.

So there is a strong movement of social prescribing

across Australia and internationally but it's not widespread. So, it would be important that these type of things are prescribed based on assessment.

For example, for this lady here I would do a loneliness assessment, social isolation assessment, which is a validated tool, and then have a conversation with her about this intervention. We would then set, if she decided yes, I'd like to use it, we would set the parameters: how many conversations would you like a day? And if she says, I'd like to have about three or four, we would set that into the software and then she would go about her normal life. We would also explore what are the intrinsic things she can do to have more contact with people and whether that's assisting with ease of telephone communication or scheduled phone book clubs or whatever it is that already exists.

Q. And who does the prescribing?
A. We would like community nurses to be doing that and especially GPs, because GPs have access to these individuals. And that's what's important with this, is respecting the ecosystem and the people that meet these older people, and it is community nurses and care workers that are in the homes of the most vulnerable in Australia and that's our referral pathway, so we would be looking to upskill them.

Then if the word count drops below that threshold which we've negotiated and set, then an action happens. So, instead of the internet of things, this is the internet of actions. It then sends a message to family, friends, volunteer phone service, it could send to neighbours, part of the One Good Street network, and then we would respond by increasing the word count through a conversation, so it's conversation as therapy, or a home visit or an activity.

Q. Could we talk through the diagram that you've got here. Can you read that from where you are?
A. So, it looks like:

"Maria is alone in the family home. Her husband Peter died seven years ago. Her children are grown up and now live with their own families.

"Today Maria has not spoken to anyone. She's feeling isolated and alone. Her CaT Pin then senses that she is at risk of loneliness."

"Maria's daughter Frances receives an alert message."

Q. And that's just a text message?
A. Correct, just a text message. Then the daughter phones her to lift the word count. Maria's phone rings, she has that conversation. So, I think for the first time we've got real-time intervention for loneliness and isolation.

Q. Can I come back to ask you more about One Good Street. You've described what its purpose is and why it was that it was developed. Can you give some examples of what's happening in the community who are members of One Good Street?
A. We established the Library of Aged Care Things or the Library of Care Things. It's Australia's first lending library of aged care and care equipment. What was happening on the Good Karma Networks, which are social neighbourhood Facebook groups that have thousands and thousands of people in neighbourhoods posting different things, we saw postings of aged care equipment or care equipment where people's loved ones either had gone into care or had died.

What we did was we started to see all these posts and we started to collect that equipment, because community nurses, social workers, OTs and physios were reaching out saying, we've got people who can't afford care equipment on NDIS, on CHSP, on home package care funding.

So we started to collect that and then clean it, tag and test it, and then give it away for free. So, we've established a lending library of care equipment which is free of charge to older people and it expressly has an aim to support adult children who are looking after their parents in their own home or in the parent's home.

So, we've given over $30,000 worth of free equipment away in the past year and a half. We run Air Con Clubs, so these are spontaneous opening up of your homes to your older neighbours in extreme weather. So, when it is 38

degrees in Melbourne for three or four days we have these Air Con Clubs that pop up and people invite their neighbours over. This is to reduce the effects of heat for older people because we know that they don't turn on their air conditioners and they're at risk, and especially if you live alone, no-one's reminding you to have a drink. This is a really organic simple thing.

Also the members knit cardigans, blankets, do a range of things where we are producing things and giving them away through all of our networks so that they reach older people. We do Christmas hampers and we also do Ride To End Loneliness which is a particular initiative from Cycling Without Age, and that is giving older people who can't get out of their homes any more because of inability or any other reason, access to the community through a special bike that they can sit in the front and we have trained volunteers that take them out for a bike ride.

Q. And so, how do older people access One Good Street, for example if it's on Facebook and they're not internet users, how do they come to know that it's available or that it's there?
A. The brilliant thing about it is, they don't have to touch Facebook at all, the street itself becomes a better place to live in for an older person. So, it's the neighbours who are active on the Facebook groups are the ones that start to reach out to those older people.

We also use our community nurses and care workers, because we've got partnerships with aged care providers, to let them know about all of those initiatives.

So, to give you an example, a secretary from a GP practice posted saying, we need equipment because there is a particular client who is very young and is palliative but cannot afford the hire of a hi-lo bed, a wheelchair, a commode and some other supplies. So, it was costing this young person $250 per week to rent this equipment and she couldn't afford it.

So, the secretary from the GP practice posted saying, "Please help", and within an hour that community had responded and we had everything we needed. Within 24 hours, all of that equipment was delivered, so that gives you an idea of the rapid response.

What was interesting was, NDIS would not fund her for the palliative care equipment. Palliative care had no money to fund her for that equipment, but when they asked the neighbours, we just saw her as a neighbour in need, so it was easy to respond, so she's received all of that equipment and continued support during the last days of her life.

Q. Can I just ask, you gave an example earlier on about an older gentleman in your street, and that you would go and get him out of bed, and there is a system in place for you to then inform family about that, and that's sort of how this works?
A. Absolutely.

Q. Could you just explain what that system is?
A. So, whenever we access an older person, it's always with their consent and also really respecting their ecosystem, which includes their family members. So, often it's the family members we're supporting initially because it's the adult children that come in with that burden, the carer stress of looking after dad but also managing family, also managing career.

When they hear about One Good Street and that we've got free equipment, and when they go and pick up the free equipment and they have a conversation with someone that's been through the same thing, they get benefit, so there's always respecting that ecosystem and it's very human-centred in that sense.

So there are pathways back, and because I work in the health care sector I'm able to help people with those pathways back and many of the members of One Good Street are psychologists, OTs, physios, et cetera, in the community. So, really there's this latent capacity within the community. When we clock off from our normal clinical jobs we're happy to share our expertise and our referral pathways to make our suburbs better places to live.

I think the key is here, we're micro-ambitious, it's just one street that I have to care for, it's not millions and millions or thousands of people which is overwhelming, because if we think like that then we've got to develop an entire system as a response. This is street-by-street, making streets better places and neighbourhoods better places for older people to live, which is very achievable

when you break it down into those components.

When you create a participation culture that's very easy to get involved, then it's easy for neighbours to say, I can change your light globes, and my street changes colour on a map and now the auctioneer is talking about it and our property prices are increasing. That's the way we have to approach these complex social problems, is looking at very innovative ways on how to engage and create participation within our suburbs that already exists, especially through Rotary and a range of other organisations, and then reward that and then create more opportunities, frequency and variety, to do a range of things to make our neighbourhoods a better place to live.

What it does do is it links with the urban renewal movement. So, this has been really key to focus on what are the themes and energy within the community, and if we've got communities mobilised around climate change, around composting, around protecting bees, et cetera, that's not too much of a stretch for them to think about caring for older people.

Q. You talked about, I guess one aspect is pure goodwill, but you're also talking about other incentives for people to want to engage in this sort of community support?
A. Absolutely.

Q. As well as people who have experience like you in nursing and other fields, it can be just members of the public who choose to participate and help?
A. Absolutely, and what we do is, within the Facebook group, is post content that is building capability. So, we're telling stories about supporting people with dementia in your community, supporting people who are dying in your community, a range of initiatives.

So today we've been posting about, in Holland I believe they have now set up a special, it's called the Chat Checkout. So, in supermarkets there is a designated checkout where you can take your time for older people and have conversations. So, that's the sort of thing we're posting, and then the response is, let's try and do something here, let's go to our local supermarket and create a space; instead of rushing past the older person, that they are welcomed.

This type of content builds a sense that our older people in our communities are VIPs, they are the corporate and public historians, these libraries, that we have to change an attitude within ourselves that they are valued and that we are part of aged care, and to a certain extent we are NDIS. The community has always been and must be. It doesn't live conceptually in government and has no meaning for those in our street, but for years we've looked after older people and those with a range of disadvantage in our streets. We need to reward that, encourage it, foster it.

Q. What has been the impact of One Good Street in terms of, I think you talked about the estimate that $30,000 of care equipment had been reallocated to people free of charge, what about how many members there are of the Facebook group?
A. So, 730-something members on our Facebook group. We recently have been giving out quilts and blankets to older people via our partners but also as a way of encouraging neighbours to go up and interact with their older neighbours.

We also have been running a range of initiatives that help lift the profile of the role of older people in our community activities. Our partnerships are really important and that's with people like the Good Karma Network, with Bolton Clarke, with Kensington/Flemington Rotary, and there is this porousness where they will say, hey, we need something; we say we can do that, or hey, you need something, we can do that.

We also post a lot of opportunities from other organisations because we don't want to produce a whole lot of stuff, we want to support what the ecosystem is already doing and running it through our platform which gives our volunteers frequency and variety. The work done in Lambeth and Frome in the UK really showed that you can transform suburbs if you make the volunteering experience amazing.

Q. Can you just talk a bit more about that?
A. Certainly. They surveyed 50,000 people in the UK and said how many of you would want to donate time to make your suburb a better place? 60 per cent said absolutely. Then they said, how many of you do something practically for your neighbourhood? They said it was only 3 per cent. So we have a design problem, that we have goodwill in the

community, and in Australia we do it in a flood, in a fire, the Australian spirit comes out and we help each other out.

This type of initiative is making that tangible and breaking up into small activities weekly and daily for people to actually contribute to their society.

So in Lambeth, they rolled an amazing program out called Designed to Scale. It was all about developing a participation network within suburbs and activating the suburb. They did a range of initiatives including communal orchards, tool sheds, a whole range of things that changed the character of the suburb.

In Frome, they did social prescribing to local initiatives, to garden clubs, to aged care activities, to a whole range of things, and they had a 14 per cent reduction in Emergency Department presentations for people over 75 with comorbidity suffering from social isolation.

So, if we can enact our neighbourhoods, enliven them with a whole range of social impact initiatives, we will see a change at the Emergency Department front door, because people are being looked after better in the community, especially those most vulnerable.

Q. What are some of the challenges that are being faced in implementing One Good Street?
A. The funding mechanisms are often financial year, but we're dealing with people's lifetimes, and sometimes there is an organic nature to what we do in the community that requires time for it to evolve, and also a risk tolerance that is different when you are doing things in the community.

So, that's one thing about the funding cycles. What I would say about funding is, the best examples in the world take all of that money that they would give individually and pull it all together, and then take all the individual heroes and all the individual initiatives and pull them all together and build capability, and it's a brilliant framework in the UK where they do that. And they build as much capability as possible, they make all of the local heros share the accountants, legal, insurance, website development, et cetera, and make them all cohesively work together rather than compete, so you form clusters of things, and then roll those out as a program of work to the

community, so there's that.

The second thing is, social prescribing has not found its full speed in Australia. So, bits and pieces have been done. But at the moment, if you and I went to an Emergency Department, no-one's assessing us for loneliness and isolation. So, we don't have referral mechanisms, and yet, everyone talks about it. So, I work with a community nurse and she'll say, I still come and give this gentleman medication because I'm the only person in his life. GPs that say, welcome, back again, I haven't got much from a clinical perspective but I know that you're here because you're isolated and lonely.

So, it is known throughout the clinical sector that this is an issue, yet we haven't found a way, a mechanism to take that, to assess for it and then to refer to it. So, rather than referring to social work, psychologists, psychiatrists, it really is that social prescription model that stays, you've presented, loneliness and isolation is an issue for you, we've done an assessment based on what you have entered in, in regards to describing your life and how you want to live, and now we prescribe for you Rotary, walking groups, the local library, the local choir, One Good Street, here's an equipment list you may need, here's support for your family, and all of that is mostly free of charge.

Q. Based on your experiences with One Good Street, what are your reflections on the strengths of such a model?
A. The cost of One Good Street is a fraction of what is being funded currently, so it's a very achievable model.

What it also does, one of the strengths, is that it takes what already exists and reorganises it. So, we have so much capacity within our neighbourhoods, yet we're not pulling together the net benefit of all of those activities. So, this type of model helps do that and it does have an eye to the tertiary sector and saving the health dollar as well, so there is a duality that you can actually reduce costs of a tertiary hospital by working with local garden clubs, local community groups to help support older people. So, there is a link there and I think that that's definitely what the research overseas has shown, is that you can link these initiatives to hard economical realities for the tertiary system.

So there's strength in respecting the ecosystem. It also creates participation within suburbs and our suburbs become better places to live. It also certainly sits alongside of and is supported by other movements within the community, such as better living cities and all the approaches of town planners and architects to make our cities better places to live, so it fits very, very nicely with that. That's what I call a coincidence of wants. So, if people want and local government want our cities to be better, this is part of that, so it coincides beautifully with a range of movement that is happening very, very locally and then scaled up to, from streets to city, to states.

Q. In terms of what you've described, there's clearly potential for broader applicability in other communities?
A. Absolutely. People have reached out to start One Good Street or One Good Town across Australia, and often they're concerned because they are either rural or non-metropolitan, that they won't have the resources, and what I find is, when I talk to them, that they actually do have a range of neighbourhood Facebook groups, that they could either join together or introduce another one that covers that with a real focus on isolation and loneliness in older people, supporting older people, and that there are all of those antecedents there within the neighbourhood.

Certainly looking at Lions, Rotary, Probus, all of those forgotten heroes in Australia who constantly do amazing things and are looking for renewal, is bringing them into this new way of doing things, and then that partnership with schools and tertiary education, and also looking at volunteerism, where individuals are shared. So, if you're a volunteer, you actually can be shared between a range of organisations which then gives you more variety and frequency, so you would volunteer more because it's incredibly exciting.

The other sorts of things that we need to see for this to scale up - but I also acknowledge that scale up may not be achievable, that there may be organic things that happen in communities that will struggle elsewhere, and that there will be place-based differences. I think that's an important thing, because we can't have assumption that one model that works here can be scaled up everywhere. There may be elements of it that may work, and I look to Men's

Shed on how they've scaled up, the Men's Sheds and the She Sheds across Australia; it gives us an idea. And when talking with them about the - that some thrive and some just survive and teasing out what are the elements of that, they're all things to be taken into consideration.

But there may be organisations and parts of the society that don't need it because they've already got established networks in place, and that's that real respect for the ecosystem, respect for the goodwill that's already out there in the community.

Q. Are there any early lessons or other factors that should be taken into account when considering replicating similar models in other communities, aside from what you've said about scalability?
A. I think it is important, yes - I think we need to evolve our sense of co-design, and co-design is just an initial phase, but co-leadership and co-production takes that citizen science even further.

There is a body of evidence around citizen science that looks at citizens conducting their own rapid prototyping, their own hybrid citizen experiments to deliver value to the community and supporting them to do that, that it is very much crowd-sourced. So, there are lessons in allowing that to happen, create space for that, allowing the organicness to happen.

But also to introduce new things, because communities don't know an exhaustive amount of possibilities for them. So, yes, importing and then changing and massaging other initiatives that have worked well, and I think that's the duality.

And having a tolerance for failure and a tolerance for things not to work, then we can rapidly prototype, acquire on Tuesdays and then work out that it doesn't work, and we need to do it on a Saturday, and we need to link it to tea and coffee and it needs to be linked to the gardening club. That's the type of environment where innovation can flourish and also local creativity can flourish. So, there's work to be done on creating environments that are very, very permissive, we can manage the risk, but allow that creativity from the community and from outside to kind of collide.

MS COGHLAN: Thank you, Mr Bush. Chair, do the Commissioners have any questions?

COMMISSIONER McSHERRY: Q. Thanks very much for your testimony, and I admire your passion at trying to connect team. I'm just wondering whether there might be some challenges, though. We've seen recently that certain organisations - I'm thinking about the Cambridge Analytica scandal and so on - is there perhaps a challenge with technology coming into the home, that the data that's gathered might be accessible by others? That's the first question.

The second question is, when you're monitoring people for social isolation, is there a challenge that other people will think, oh, someone's going to come to help: if someone doesn't, well, who has a duty of care, I suppose. As you said, it's very much based on a participation culture, but what happens if people don't participate?
A. Absolutely. So, the producers of the technology are very cognisant of that. So, the challenge for them is to ensure that that data security is well in place, and that's incumbent on the developers of that, and also the aged care providers that are utilising that for their own safeguards to ensure that it's a very, very closed system; that, if you've got sensors in your home that are letting me know whether you are - and you've consented to it - that the data is stored securely and that the messaging that goes to the community nurses to say you haven't gotten out of bed - because it exists within a model of care - and though the frameworks and safety guards around the model of care should be protecting. But that's an evolving conversation.

To confirm that, on Facebook no addresses' identity is ever revealed, so that was all done behind the scenes, nothing is ever put out into Facebook around this person, naming them, needs help; that's all done behind the scenes to protect people's privacy, their autonomy, and that's incredibly, incredibly important.

The one thing I would say about - because often the conversation is around, what's the risk for elder abuse? The more people you have in your life from diverse perspectives the less you're able to experience elder abuse because you're having a whole range of people check up on you. So it is protective to have a range of people in your life. But we can control for that, to ensure that what

information you want to share is shared responsibly and we've got safeguards in place, such as all our volunteers are police checked and have an interview, for example - first one.

The second one was about the duty of care. So, the partnerships arrangements with One Good Street and care providers like Bolton Clarke and community houses, that's where that added layer of protection is.

When community nurses visit older people and no-one answers the door, they often will talk to neighbours, or the neighbours will come out and see the car and say, hey, I haven't seen this individual, I think they're in hospital. So, the neighbourhood is a source of information.

By providing them with a legitimate place at the table as part of the care team, we can then build capability and control for risk, but also, we get more data points about that individual and it's a safety net for them.

What we would do, for example with the CaT Pin, is to have a range of SMS alerts, and you can build the technology so that it sends an SMS to you, because your grandmother hasn't spoken all day, and then if you don't respond it has a secondary and potentially a third contact, so you've got that process in place.

If it's been prescribed by a GP or a community nurse, then we know that we've got community nurses and care workers going in daily, because this is really targeted for those individuals that are receiving services already, or are on the at risk registry because they're 85, live totally alone with no family in West Melbourne, for example. That's the type of person who already exists within a framework of duty of care because they're receiving a range of services through Package Care, for example.

Q. Could I just ask, as a quick follow-up, which of the four suburbs are involved?
A. So, North Melbourne, Kensington, Flemington and West Melbourne.

Q. And you're thinking of rolling this out across Melbourne and perhaps country areas? You mentioned --

A. Correct. If there's an appetite for it, and co-leading, co-producing and co-designing it with those local neighbourhoods.

COMMISSIONER FELS: Q. I imagine you've come across the Putnam, Bowling Alone, and all of that which some of us got our education from, and I think it was called something like, "The collapse of American community", but also some revival. So, how do you see all that literature which tells us that the community is collapsing, but what's your take on that in the light of all the excellent things that you seem to be doing?

A. I feel that there is latent capacity within our neighbourhoods, and often when I present about One Good Street people come up afterwards and tell me, "This is how we used to be", and especially in rural places they talk about, "This is rural life, we all looked after each other." And I often respond that, yes, but often it was gendered, so it was certain members of the society that would do the majority of this work, and in 2019 it has to be more shared amongst us all.

And also, with the possibility of rewarding and accrediting and social credits for example, it offers new opportunity to reward people that is not monetary.

One thing I would say is that there's no - I'm not ready to put the curtain down on community activism as yet. So, we've got incredible energy around environmentalism, about making our homes more sustainable and making our suburbs and cities more sustainable, and that's what we're hearing about constantly. And that for me, I'm stretching that to include older people, isolation and loneliness.

So, I haven't discovered apathy in the community on this. What I've discovered is that there is a pool of people that want to redeem the ageing experience of their parents and they have put their hands up to say, I want to help older people, because they weren't satisfied with how their mum and dad were treated in aged care, so they're highly motivated to get involved.

What I think can assist is coupling One Good Street and this movement to help older people thrive in our society and respect them more is the fight against ageism, which is incredibly important; to look after CALD communities and LGBTI seniors as well, and couple that with

other energy flows of urban renewal, and we see that as a whole and package it as a whole. There is no end of energy in people that want to change. So, I see the horizon thick with solutions.

CHAIR: Q. I have one last point to ask you about in terms of the reflections about that. We've heard a lot through this Royal Commission about the stigma around mental health and mental illness, and thinking about whether you have experience or how you think the model applies for those community members who might be older but also have mental health issues and what role something like your One Good Street could have.
A. I think, the key would be to focus that individual as the neighbour who needs assistance, and if we view them through the lens of that neighbour: this is just someone in my neighbourhood who may have a range of things in their lives, but they are a neighbour, so they're an enduring presence in my street.

So, I can be informed via providing content through the Facebook group about anxiety, about depression, about suicide risk in older people. There's ways we can inform the community, what we call at the Health Transformation Lab, guerilla information provision, where you are messaging the community on a regular basis in ways they're not expecting to hear about: the suicide rates of older people, you can do that through a range of social media channels; people with mental health issues who often are well engaged on social media when they've got digital connectedness, so there's ways to provide capability-building within the suburb.

The referral pathways are really useful so that - and this happens now, so Ozanam House will call me and say, we've got somebody who needs XYZ, can you help, and I push that out saying, this is what I need. Or I've got a range of people that can already jump in.

So it is those referral pathways and the timeliness of it, the ability to do it in a day. Some of the organisations can't believe that they've phoned in the morning and then, on the way home from work, one of the volunteers already drops off the equipment. That's unheard of. They expect a wait, they're actually shocked, oh my God, here it is, you've had a response? But that's how the community can respond.

So, those trusted partnerships, those referral pathways in and out, building capability, because people within our neighbourhoods experience a whole range of mental health fluctuations in the phenomena of their life, and there is this capacity to assist, to guide, to support, all through the lens of this is just a neighbour who needs help. It really normalises that as part of the tapestry of our neighbourhoods.

CHAIR: Thank you very much.

MS COGHLAN: Thank you, Chair. May Mr Bush please be excused?

CHAIR: Yes, thank you very much for your exciting developments and thank you for coming and giving your evidence today.

<**THE WITNESS WITHDREW**

MS COGHLAN: Is now a convenient time to break for lunch? I understand we'll be returning at 1.45.

CHAIR: Thank you

LUNCHEON ADJOURNMENT

UPON RESUMING AFTER LUNCH

MS COGHLAN: The next witness to be called is Jane Anderson, and I call her now.

<**JANE ELIZABETH ANDERSON, affirmed and examined:** [1.50pm]

MS COGHLAN: Q. Ms Anderson, you've provided a statement to the Royal Commission?
A. Yes, I did.

Q. I tender that statement. [WIT.0001.0058.0001] Can you please detail for the Commissioners your background and experience?
A. Most previously to the current role of the Latrobe Health Advocate, I was the Regional Director of Anglicare Victoria in Gippsland. Before that, I was a lawyer in community practice and also private practice and, before that, I was a member of Victoria Police for 11 years.

Q. You mentioned in your statement you have nearly 20 years of experience working with Latrobe Valley communities?
A. Yes. I moved to Latrobe for work about 20 years ago and have lived and worked in Latrobe for that time.

Q. Can you just describe then your current role and responsibilities as the Latrobe Health Advocate?
A. I was appointed to the role of Latrobe Health Advocate in May last year and commenced in June and my role is to hear from the community and give advice to Government and stakeholders and services around what the community is looking for to improve health and wellbeing in Latrobe.

Q. Can you tell the Commissioners a bit about Latrobe City, its location, its population, those matters?
A. So, Latrobe City is about 150 kilometres east of Melbourne. The population's about 75,000, and there's a number of towns in Latrobe. There's four major towns: Churchill, Moe, Morwell and Traralgon, then there's seven smaller towns. The history of the area has been farming and power generation for some time.

Q. What is the focus of the Latrobe Health Advocate?
A. So, my role is to hear from the community. It was a recommendation from the Hazelwood Mine Fire Inquiry. There was a fire in Hazelwood in 2014, and from that fire there was an inquiry because of the concerns from the community about the impact on their health from the fire, and also why the fire occurred in the first place.

So, the recommendation was to establish the role of the Latrobe Health Advocate as well as the Latrobe Health Innovation Zone and the Latrobe Health Assembly. The words from the inquiry for the role of the advocate was to be a champion for the voice of the community in looking at change to improve health outcomes in Latrobe.

My role is: I report directly to the Minister for Health and, as I said, give advice to the Government on what the community is looking for to improve health and wellbeing. It's an independent role, so I'm not a part of any other service or government department, and it is to be the voice for the community.

Q. You've mentioned the Latrobe Health Innovation Zone

and the Latrobe Health Assembly. Can you just elaborate on those aspects?
A. Yes, so Latrobe City was designated as the Health Innovation Zone, which in essence means it's the area that is dedicated to improving health and wellbeing and innovating, doing things differently in doing that.

The Latrobe Health Assembly is a unique structure in its set up, in that it's a legal institution that brings together the CEOs from the hospital, the community health service, local government and the Primary Health Network, and also representation from the Department of Health and Human Services with community members on the board, and then also the assembly itself has community members.

It's unique in the fact that it is legal, bringing those people together and working with the community to ensure community-led decision-making and community-led improvements for the health and wellbeing in Latrobe.

Q. So, how does the role of the Latrobe Health Advocate contribute to the zone?
A. So, my role, as I said, is independent but works in collaboration with particularly the Health Assembly and with the other organisations within the Health Innovation Zone. A key part of my role in hearing the voice of the community is to engage the community and hear from them in a way that they may not have had their voice previously.

So, I particularly focus on people who either don't recognise their voice or don't have the opportunity to provide their voice, and I've engaged with the community in different ways: in going to the community where the community is, acknowledging that they're living in different contexts and they're in different places.

So, I've done things like catch the buses and talk to people on the buses and at bus stops. I go to community events and I ask open questions from the community around what are their priorities for improving health and wellbeing and what are their suggestions for improving health and wellbeing.

So a key part of my role is hearing those voices from the community in different ways so they can have their voice, and then I take that voice through to other decision-makers, whether or not it's government or whether

it's health services or whether it's the Health Assembly so they can adapt and change the way that they are providing health services according to what the community is wanting. So it is about community-led decision-making in improvements in the services.

Q. You've talked about taking the things that you hear to the Assembly. Can I just ask more specifically how your role as the Health Advocate works with the assembly?
A. Yes, independent of the assembly but working closely and collaborating with the assembly. So, I will attend Assembly meetings at different times and I will attend the board meeting of the Assembly, but then I also interact with the Assembly members individually and separate from that as well.

Q. One of the things you mention in your statement is that having community members and the leaders of the major health services in the room together creates a space where the status quo can be challenged?
A. That's right. It is unique that they are coming together in that legal structure, and so, it is an opportunity to bring what I'm hearing from the community through to those people as a group, and so, the opportunity to actually influence the way that they're doing things is greater.

Q. Can you talk about some of the strengths of this model that you've described?
A. So, what's particularly strong in my view of the work within the Latrobe Health Innovation Zone is that it is localised and it is looking at the place and the context in which people live their lives.

We're aware in Latrobe that there are health challenges, and those challenges have been there for quite some time. So, by having a Health Innovation Zone we're doing things differently to improve the health, because health hasn't been improving there recently, so we do need to change the trajectory of some of the issues.

One of the strengths is being aware of the context in which people live, having the community-led decision-making, and also people having a shared focus around what the issues are in Latrobe. So it is the opportunity to really highlight the importance of health and wellbeing. While we've got economic development we're

bringing health and wellbeing as a priority together which, when we join them, we've got the greatest opportunity for a prosperous community.

Q. One of the strengths you identify in your statement, just picking up on what you've said, is about these place-based approaches and methods that can empower communities and individuals in that context. Can you expand on that?
A. Yes. So, having community leadership in relation to different initiatives, having their strength at something like the Latrobe Health Assembly, it gives the opportunity for them to inform the things that need to occur.

One of the examples is the Hello Campaign. So, people identified in Latrobe that there needed to be greater social inclusion, greater connection between people. So, Lifeline Gippsland were able to look at what could be done in that space and they were able to bring the community together with the Health Assembly and also then with the government to see what could be done differently.

The Hello Campaign was one of those initiatives that came from the community informing directly the services and what could be done. It started from a suicide prevention aspect and as a precursor to having a "Are you okay?" conversation and actually establishing a relationship with someone before you could say: "Are you okay?".

Q. Do you have any idea about how that's gone in practice?
A. Yes, I've had feedback recently when I've caught the buses this week and I've talked to people, and the Hello Campaign was initiated just a couple of months ago, so when I caught the bus this week people actually talked to me in the street about the value of that campaign.

With that campaign people are actually handing out "Hello" cards. So, they are seeing someone in the street and they are saying "Hello" when they are handing out these cards which assists people in how they can say "Hello" to others, and they're doing it in cafés and sporting grounds and different locations, and people in the community are actually talking about saying "Hello" to more people.

Q. Is there broader potential for application of this kind of model in other communities?

A. Yes, I think there definitely is. I think there's some learnings from how things have occurred in Latrobe that we would need to adapt, but certainly there is potential to use the model in different places where it was appropriately needed.

Q. Can I ask you about those learnings or those early lessons, and your view really on factors that should be taken into account when considering replicating or expanding similar kinds of models in other communities?
A. I think it's really important that there is time spent on developing the relationships in which people are working. I think often we talk about partnerships but actually for the model to work we need true collaboration and that means that people are actually compromising and that takes a trusted relationship to compromise and to come to true collaboration, so we need to invest in the time.

We also need to be very conscious of the power imbalances and having good communication. There's no doubt that people from the health sector, like other sectors, have a language and people in the community don't necessarily understand that language. So, it's important that unequal power issues are identified and addressed and people are aware of the position that they stand in, so people can come to things equally.

It's also important that we build on the existing strengths within the community. So, whilst we have a Health Innovation Zone and we need to change things, it's not everything that needs to change. So, it's important where there are small organisations like neighbourhood houses who have been trying to innovate and doing things differently and are innovating, that they're actually taken on the journey and they're not excluded or ostracised from the processes, so the strengths in the community are built upon.

I think it's also important that, whilst things are focusing on health and wellbeing, there's lots of different activity that occurs in the community, whether or not it's from local government, state government or organisations that are focused on health and wellbeing, and if we're not careful to align the energies and the action then we can have lots of things going off in different directions. So it's important to align the work and have a common agenda.

I think that engagement with the community is also important. When I commenced in the role people talked about consultation fatigue and that people in the community were tired of talking to others, and what I actually found is that, when I was going out into the community going to places where they were and asking open questions and listening to what they had to say, that there was no fatigue from the community; they absolutely wanted to contribute to change, but I think it's about how others are supported to engage meaningfully with people and actually hear what people have to say and want to say.

I think there's probably another area that is a learning which is also around how local context operate in a statewide and a national arena as well. So, when there is statewide policies and they are being sought to be changed and give value to what the community is looking for, how those statewide policies can be adapted to the local area.

The last area that I'd say is a learning is around risk. It's difficult for governments and departments to take risk, and it's challenging for the community to allow others to take risk and allow for failure as well. So, I think we need to have the right environment that allows for those risks to be taken.

Q. You may have covered this, but you also say in your statement:

"The role of governments and services needs to continually evolve."

A. That's right. I think things can be done at one point in time but one of the things I would say about innovation is that it is a continual learning and a continual development, so people need to be - when I say people, organisations, all the various stakeholders - need to be able to adapt to things as they go along.

Q. Reflecting on your time in the Latrobe Valley, what are some of the challenges and hardships that the community has experienced?

A. I think some of the experiences in Latrobe particularly in the last 30 years are quite unique from my experience. It really commenced, some of the issues there, from the privatisation of the power industry back in the

90s, where that was a safety net for people having work, and for families that was often the career trajectory that they looked for their family, where they would be safe and they would have secure jobs.

So, from the privatisation, that impacted the community significantly. Then we've had large impact disasters. From the 2009 fires through to the 2014 mine fire and then also now the closure of coal-power stations. So, it's quite a complex community. There's generational issues. It's how the community can be supported to transition into a new future, because it certainly is a transitioning community and people are looking for what is meaningful for them into the future and what can they look for.

Just this week - again when I was talking on the buses - people were saying they're looking for motivation: so, what's the motivation that is in Latrobe for individuals to actually change things and transition to the future?

Q. One of the things you talk about in your statement is the conversations with people living in Latrobe, expanding on perhaps the conversation on the buses, that mental health and wellbeing is the most common issue raised?
A. It has been the number one issue that people have raised with me in the last 12 months. So whether it is on the buses or at community events or people coming to talk to me, they have talked about their concerns for mental health of themselves or particularly for those in the community. It's been quite caring, the conversations, being concerned about others.

They've talked about often the connection between mental health and other issues, whether it's family violence, alcohol and drug, whether it's stressors in day-to-day life. They've also talked about their concerns for the person down the street. There's an example that comes to my mind when I was talking to people at the Men's Shed, and they said that, "We know that there's a fellow down the street who's by himself, but when we knock on the door he doesn't want to engage in conversation, but we know he's not coming out." So they've got concerns around people being connected to other things in the community and particularly social inclusion and loneliness.

Q. One of the ways that you are informed about the health

and wellbeing is through the Hazelwood Health Study. Can you just talk about that in relation to particularly students, young people?
A. Yes. So, it was a recommendation from the Hazelwood Mine Fire Inquiry to actually have a long-term health study, and the health study has looked at the psychological impacts of the mine fire. They have identified the stress that people have felt from the mine fire, but also the stressors that children in schools felt.

Sometimes those stressors were impacted by their parents, and so, children have suggested that there are things in schools to support them to deal with those stressors when they may not be sleeping at night or it's impacting their studies, and also that there be communication with them so they can be aware of the situation and they're not necessarily relying purely on their parents whilst information from their parents is very important, but they wanted to see from other areas as well.

Q. You touched on this before, but you talk about that through your engagement with people in Latrobe you've had the privilege of hearing many ideas and aspirations for a prosperous and healthy future.
A. Yes, people have been, as I say, keen to have their say and they are very conscious of wanting to change things so it is better and they want to contribute to what it is that is better in the future.

Some of the suggestions that they have had around their ideas and things that work, have particularly around events where people do come together. I've attended some of those events and what I've found, is that the consistent thing is that there's a shared interest and then also a social activity.

So, I went to a group that's the Yinnar Wellness Group and they are a group of people aged from 60 to 98, and they actually talk about the pieces of metal in their body. So, they're not very active, and what they find is that coming together in this activity once a week, so it's called the Yinnar Wellness Program, they are coming out, they connect with others that have shared experiences and they have an exercise therapist who takes them through very gentle exercise, and that is having significant benefits for them.

They even talked about one person there who wasn't

going to be released from hospital until the hospital saw the exercises and the program that they were going to do here, so it actually allowed them to be released earlier from hospital to come back into their community and connect with others.

There's a range of different activities that are occurring in Latrobe that do bring that shared focus and social activity. Another one that has had great impact is Streetgames and when I've gone and visited Streetgames I've gone to areas where I know people are experiencing really difficult times. There's often experiences with child protection involvement in their families, issues in relation to financial stress, family violence issues, and I've seen those families at the Streetgames events, where the kids have got engaged in the activities, again because it's accessible to them, they see that it's happening, they see it publicised and they just see people gathering.

I've been at one of the local schools where there was over 80 people at one of the Streetgames events. What also happened is, from the kids coming together and connecting, the parents were then actually connecting as well, and the parents were then saying, "We want to do other activities." They said, "We want to play tennis", and so, then Streetgames provided activities for the parents. It's that sort of activity where people can come together in the community.

It's similar through other activities like Parkrun, Heart Foundation walks where I've been on walks with people, and again, it's people that - one person told me her story where she was recently widowed and she didn't know what to do, she didn't know where her friends were, and someone suggested this walk to her, so she came on the walk and connected with other people as well. So, those sorts of initiatives and ideas have really benefitted people in the community, and that's the sort of thing they say is important for them.

Q. You talk in your statement about your engagement with local Aboriginal communities.
A. I've heard from the Aboriginal community the work that they're doing, there's particular places like The Gathering Place where people are coming together where they feel that it's a safe place for them to come.

But also, just in NAIDOC week recently, to see the amount of events where people were coming together to celebrate NAIDOC. There was the flag raising in the street in Morwell, and I've been to that for a number of years. And this year when I went there, there were actually people in the street: there were so many people there that they were in the street. So, it's increasing numbers of people coming together celebrating family fun days.

I'm seeing a really strengthening connection within the Aboriginal community and people, again, wanting to come together and share their experiences with each other and celebrate where they can celebrate.

Q. You refer in your statement - and I'll just read this part to you:

"Experiences in Latrobe have shown that, for some, resilience can be strengthened through adversity."

Can you just expand on that?

A. What we found through the Mine Fire Inquiry, that it was actually the community that called for the inquiry, both the first inquiry and the second inquiry. They weren't satisfied with the results of the first inquiry, so they had a very strong voice in seeking, and they were demanding, the second inquiry.

So, what I've seen through working and living in Latrobe - and I experienced the impacts of the mine fire along with many other people - I saw the community voice getting stronger and stronger, and I haven't seen it as strong as what it is now.

So, what I've seen is that through that adversity of the mine fire, in some ways it's been a catalyst for change, but it's also been a catalyst and a call for the community to strengthen what they need and for them to take on responsibility to say, we want others to respond to what we're needing.

Q. I want to ask you about what it takes to support and improve community resilience. Can you address that, firstly, at a government level?

A. I think, particularly from a government perspective, there needs to be an appetite to look at the funding and

the policy to do things differently and to acknowledge a broader definition of health.

What I've found is places like neighbourhood houses, Men's Shed, local community groups, they have a real part to play in supporting people's improvement in mental health, and I think there's space for them to be acknowledged more in funding models and policies.

I also think there's space to look at more sustainable volunteer models. So, where I've been to community gardens, I see volunteers there who do an amazing job, but often what they need is something, whether or not it's a partnership with another organisation or it's a bit more funding, to just give them that backbone from a funding/administrative perspective, to be able to sustain the work that they're doing.

Q. Moving on then to the mental health and broader health education and social services sector.
A. I think the things that the sector and other services can do is particularly consider the approach from services and how they can change their approach: to be approachable, to be accessible and to show empathy.

There's one person who I talked with on the bus six months ago when I was on the buses - and I'm talking about the buses because I've been there this week so it's fresh in my mind about people's experiences - and I talked with her again on the bus this week, and she said six months ago there was nothing for the age group of 18-22 to do. She said there are things for younger people, things for older people, but there wasn't anything for her to do.

What she said to me this week is actually, there's now a youth space where she feels as though she's able to go to that space, and it's something where she can be comfortable and she can sit on the phone and access the WiFi if she wants to or she can talk with people if she wants to, but it's just a welcoming place.

She also talked about mental health services that she's accessing and that too had improved. They're now in her local town, so she doesn't have to get public transport to another town. She said, in the environment that she's seeing them, it's in a community setting. She said they've

got resources in their reception area, so she can look at the resources if she wants to.

Also, there's knitting, so if she wants to she can sit and knit or she can sit on the couch and again she can talk to the services if she wants to.

I think there's particularly something in that space around approachability and accessibility for services.

Q. What about in the community?
A. The role for the community, from what they've been saying to me, is the priority around social inclusion - there's a role for the community to assist in reducing stigma and that's something that they have been concerned about.

So, it's what the community can do in their conversations, and that's part of that Hello Campaign that I talked about, how they can come together and support that and have conversations with others so there are just everyday conversations about, "How are you going?", "Hello, how are you going?", or, "Are you okay?", that again reduces the stigma of mental health.

The other thing about community, the thing that they can do, and they are doing, is bringing people together - I think this is where we can see more of that. I've seen in a local community centre in Traralgon East where again they heard from people in the community what they wanted to do, and the community said, well, we need activities for children, we need activities for families. We also need to access food, because we don't have a lot of food, and they also talked about clothing, and so, at this community centre now there's pop-up op shops. So, the op shop just comes in and people can get clothing, they engage in children's groups.

There was someone who I spoke to at that community centre where she actually said, that morning she was feeling the weight on her shoulders in her home, she's got chronic illness, and she wasn't sure about going out the door. But she knew that there was a lunch at the community centre that day, so she actually walked out the door, and then she said, when she got to the street, she walked up the street and she felt better for going for the walk up the street. Then when she actually got to the centre, she actually described the weight coming off her shoulders and

how good she actually felt being there. So I think it's those sorts of things that the community can do and wants to do, if properly supported, to bring people together.

Q. How does disadvantage, education, and employment impact mental health from the Latrobe experience?
A. What people have talked about or what I'm aware of particularly is issues of generational disadvantage. So, where we have seen from the impacts of different events over the years, where kids are born in an environment where there may be family violence in the home, or there's financial stress, and their parents haven't been able to get work, and so, kids are born not knowing the skills and how to deal with different challenges. So, what can help them to break that cycle, so I do see issues of generational disadvantage.

Those families then, the support that they need to actually be the best parents they can when they have kids. So, I can see that in different areas. But what I hear from people is, their desire to have that purpose in their life. So, whether or not it is volunteering or whether it's about sharing an interesting, or whether it's about seeking a job, and they do want to have more skills.

I've heard from people around the value of free TAFE, what that meant for them, that they actually did want to educate themselves but it just wasn't something that they were able to do. So, having the accessibility to education and then how that is able to support them into employment has been valuable.

But then, the employment challenge in itself has impacted their mental health. So, they've talked about the effect of applying for jobs and getting knock-backs and how that affects how they're feeling.

I've heard comments from people from a different cultural background of the challenge of getting their skills recognised, and someone actually told me that they applied for a job and they were a qualified person. And, when they sought feedback because they didn't get the job, the response was that they should change their name.

So, the impact of those sorts of things, where people are wanting employment, they want value and purpose in their life, and there are prejudices and issues that are

pushing against them, are very challenging.

Q. Can I ask you about perhaps a broader area, which is that: you say in your statement there are some areas, and the Latrobe Valley is one of them, for which there is a stigma about the location?
A. Yes, I think as a result of particular events and in particular when it can be sensationalised by the media and perceptions that people have of the area, then that impacts how people feel about themselves, it impacts how they feel about feeling proud of that area.

There's a campaign at the moment, which again is an initiated through the Health Innovation Zone, called "We Are Latrobe", and it's about drawing out people's stories about why they are glad to live there and why they are proud of living there. Because we do know that the stigma affects how people feel.

Again, I heard that on the buses when people were talking about motivation, how do they define motivation? What is their future? So, it's great to see the positive campaign where those sorts of issues can be addressed in a positive way using the stories of people in Latrobe to reduce the impact of an outside view of people in Latrobe.

Q. Looking to the future, what can be done to prevent mental ill-health and better meet the mental health needs of the community?
A. I think there's a range of things that need to be done, but what I would say in particular is taking a view of health services, a broader view of health services, so looking at a social model and holistic view, so people's lives are taken into account when health services are providing a response.

I talked to someone - and this relates to employment and getting financial support - but she was talking about getting services from Centrelink, and she was being required to go and apply for jobs. She was six months pregnant. She disclosed to me that she had lost a baby in the year before, so she was actually very protective of her pregnancy, and so, she didn't feel comfortable going out and seeking employment when she was six months pregnant. She also said, "Who's going to employ me when I'm going to have a baby in three months' time?" So I think it's those sorts of things, taking awareness of the context in which

people are living and taking a broader view of their day-to-day lives.

I think there's also a role in reducing the stigma, particularly in regional areas. There's a part that health services can play in reducing stigma because they are a part of the community and they are a large employer. So, the roles that people in health services in their own community in reducing stigma can impact others, so I think there's a real role there in the prevention space.

The other area around prevention is addressing the issue of social isolation and being concerned about people where they don't come out, or you can't get in through the door. People have talked about - there's a model that's being explored in Latrobe at the moment around social prescribing, so linking people into different activities that links that shared interest and a physical activity and social aspect together.

I think there's another thing around the design and location of services. So, there are models internationally where emergency departments are redesigned so people actually - it's not that traumatic impact of going in there, it's almost an enjoyable thing, if you can say it in that way, to go into the health service door.

People even talk to me about the Royal Children's Hospital here, how it is a great experience for people to go to, so I think there is something about the design of services so they are in their location and their accessibility is not daunting for people.

Q. What significant social changes are likely to affect reform efforts aimed at better preventing and responding to mental health challenges?
A. I think some of those things are in relation to, particularly in Latrobe's example, the transition from coal-powered stations, transition to other energy sources. So, that's something that really needs great awareness, that it's impacting people's mental health in a positive way and giving them a view towards the future.

I think the other thing is in relation to technology and the value of human connection. So, people commonly are talking to me about wanting to talk and connect with others. I think, whilst technology provides great

opportunity to get to people in different locations, there also needs to be a balance with the importance of human relationship.

Q. Drawing on your experiences, how should local communities be engaged on the design, implementation and delivery of reform efforts?
A. I think it's really important that the engagement is meaningful. As I said, when I started people talked about consultation fatigue, but that's not my experience in the community. What I've heard people say to me is they want to be heard, they want to be valued and then they want to see action as a result of what they've had to say.

So I think there is a risk in listening and consulting with the community if actually there isn't change as a result of what the community is looking for. So, I think that engagement has to be meaningful, it has to value what people say.

It has to be cognisant of the experience in which people are living their lives. Again, just yesterday I spoke with a fellow who was talking about the cost of getting his licence, and it wasn't something that would ordinarily have struck me, but his mother is blind. So, it cost him $7,000 to get his licence because he had to pay for private driving lessons.

So I think it's being conscious of people's day-to-day lives, what they're facing, to listen and engage and give value to their experience and to listen openly and not make judgment.

Again, another person said to me she was receiving family violence support, and she felt judged because she was needing to get services to address issues of family violence, and she felt that there was a judgment of her that she needed to get those services. So, I think it is that non-judgmental approach to people to listen to what their suggestions are.

Q. One of the other things you mention is reaching out to communities at times and locations that suit them.
A. So, what I found is, my job is certainly not a 9 to 5 job. So, I go to community events, I go to locations where I know people gather. And, this is talking about how people recover from events as well, that there was a

barbecue in Yinnar from the recent bushfires there, and so, people were coming together in the recovery stage of that and so I was able to go there.

It just so happened that at that event they also had music, the Strzelecki Stringbusters. So they had again that social activity and people coming together to address an issue. It just so happened at that event they ran out of sausages because there were so many people that came to the event and, of course the butcher was there, it's a regional area, he was able to go down the street and go and get more sausages and they could cater for a lot more people.

But it is about going to those locations where people already are, rather than requiring them to come to something else.

MS COGHLAN: Thank you Ms Anderson. Chair, do the Commissioners have any questions?

CHAIR: Q. I've just got one. Thank you for giving us that overview. We heard this morning evidence about the importance of the broad range of social determinants of mental health being taken into account and the value of schools becoming part of a community hub and their Our Place model, and we heard that Morwell is one of the potential sites.

Just noting the fact that your Assembly is largely made up of members with a health focus and local council. What do you think of the value of a broad approach and understanding of the planning, I guess, across the range of services systems and the advice you could give in your role beyond the health service provision?
A. Very important people coming together from lots of different perspectives, and actually in the membership of the Assembly, so separate from the board, there's about 45 people in the membership of the Assembly and those people come from a range of different areas: some of which come from education, some come from other agencies like the EPA and others are community members with whatever experience they have.

One of the programs that actually was initiated in Morwell was the Nurses in Schools, and that came from the identification of an issue that the school had around a

health issue, and they brought together health services and education and others to actually introduce the role of nurses.

And what that meant in that area, again where there is generational disadvantage, so people's complexity in their lives, they've just got so much going on, where they've got kids needing different medical appointments and they might have their own health issues, it was a way that the kid's health would be prioritised through the school.

So the nurse came in and was able to support children, then that moved through to dental programs, but it's also moving through to relationships between the nurses and the parents. So, now the parents feel comfortable going and seeking out health services, but then that also moves through to parenting programs and other supports and linking the parents through to the school so parents are not feeling as though that's a foreign environment and can be intimidatory towards them.

CHAIR: Thank you very much.

MS COGHLAN: Thank you, Chair. May Ms Anderson please be excused?

CHAIR: Yes, thank you very much for your statement and your evidence today, Ms Anderson.

<**THE WITNESS WITHDREW**

MS NICHOLS: Commissioners, the next witness is Scientia Professor Helen Christensen. I call her.

<**HELEN MARGARET CHRISTENSEN, affirmed and examined:**[2.32pm]

MS NICHOLS: Q. Professor Christensen, thank you for joining us from Sydney today.
A. It's a pleasure.

Q. Are you a Director and Chief Scientist at the Black Dog Institute?
A. Yes.

Q. Are you a Professor of Mental Health at the Faculty of Medicine at the University of New South Wales?
A. Yes.

Q. Are you also the Chief Investigator for the Centre of Research, Excellence in Suicide Prevention and also a National Health and Medical Research Council Elizabeth Blackman Fellow in Public Health?
A. Yes.

Q. Does your research focus on using technology to create evidence-based innovations to prevent depression, anxiety, self-harm and suicide?
A. It does, yes.

Q. Between 2005 and 2012, you were the Director of the Centre for Mental Health Research at the Australian National University?
A. Yes.

Q. From 2017 to 2018, you were a non-executive director at the organisation called "R U OK?"
A. Yes.

Q. We do have a copy of your extensive CV, so I won't ask you any more questions about yourself, but I will ask you about Black Dog. Can you please tell the Commissioners what Black Dog is and what its aims are?
A. The Black Dog Institute consists of around 400 people. What we try and do is take research evidence and evidence-based practice and put it into practice in communities, including schools and workplaces. So, it's a translation of what we know from the research evidence into practice.

Q. Does it particularly focus, at least in part of its work, on online and app-based interventions which use cognitive behavioural therapy to deliver interventions, particularly to schools?
A. Yes, it does.

Q. How is Black Dog funded?
A. Black Dog is funded, like a lot of medical research institutes, from a combination of different sources. So, we receive $1.4 million a year from New South Wales Government to help with our educational and clinic programs. We receive quite a large amount from National Health and Medical Research Council and ARC. We tender for Commonwealth grants and a number of our programs are funded by Commonwealth tendered arrangements.

The total amount of government funding we have is much lower than the amount of money that we get from philanthropy or competitive research grants.

Q. Is an important part of Black Dog's methodology employing randomised controlled trials to create the evidence base for the interventions you then implement?
A. Yes.

Q. Is that an unusual thing in this field of endeavour?
A. No. I think, if you're looking at medical research, gold standard way of doing research is to employ a control group and compare that with an intervention. It may be a little bit unusual to do this on app-based and online programs, but our total commitment was, we want to show this is as good as medication and have exactly the same level of rigor as you would normally apply to any psychiatric intervention.

Q. I'll ask you about your particular programs shortly, but on the point about it being as good as medication, what have you found?
A. Well, the evidence not directly from us but from a large meta analyses, shows that cognitive behaviour therapy is as effective medication, and indeed that online programs, especially those with some blended component with a human are as effective as medication.

Q. Is that particularly to treat anxiety or depression, or both?
A. Both.

Q. And the research specifically concerns those two conditions?
A. Yes.

Q. When you say "as effective as medication", you mean medication directed to those two conditions?
A. Yes, antidepressant medication.

Q. When you referred a moment ago to "a blended human component", what did you mean by that?
A. Yes. By that I meant that, you can have completely stand-alone app and internet interventions, or you can have some amount of human support in provision to the person as they work through the program. So, you might not

necessarily have a psychologist but somebody who would check in to make sure that person has undergone that program, or had any problem with a particular module of that program and having that blended if you like support does add to the effectiveness, but even stand-alone, completely automatised online programs are effective.

Q. Before I go to how you implement them, can I ask you to illustrate these kinds of interventions by talking about one of your programs, namely SPARX-R?
A. SPARX-R is currently on trial in New South Wales, we're trying to approach 20,000 young people. The goal of it is to show that you can do prevention programs at scale in Australia.

So, if we are successful, we would have one of the largest trials, probably the largest trial in the world. Our approach is that, rather than do it by testing something in the clinic, we try and test it in the wild, so in fact the laboratory is a real world setting.

So, if a school agrees to be part of one of these large trials, we will set up a time and place to go and talk to whoever's in charge of the mental health of the school, arrange for the time in which we'll, say, implement a six-week program. We will get consent from both the student and the parent beforehand, and then we turn up on the day. We would load up the particular app and they would have already provided consent and they would undergo the program.

So, SPARX-R, which was developed in New Zealand, is actually a game, and so, you choose a hero and you go through this world where the aim is to get rid of dysfunctional thoughts, which is the basis of cognitive behaviour therapy. So, you know, you end up by arming yourself with different strategies, and so then the person would do that usually in the classroom curriculum for six weeks, one hour a week. At the end of six weeks we would assess them by an online questionnaire and then we usually follow-up for 12 and 18 months.

Q. The purpose of the follow up is?
A. To determine whether the SPARX app has been more effective long-term than a control condition. So, usually we have a control condition, sometimes it's just normal school activities, but sometimes it could be what's called

a placebo intervention.

Q. Can you tell the Commissioners about Sleep Ninja which is another of your applications?
A. Sleep Ninja is an app that's on a phone, it's designed for adolescents. The idea is that, if you can change kids' sleep patterns, then you can actually lift their mood and prevent depression. There was early work we did in a trial with adults, that showed we had 1,200 adults from around Australia. We did a program called Shut Eye and we showed that it was as effective as cognitive behaviour therapy in reducing both sleep symptoms and depression in adults, and there was no contact between anyone except the app with the person who was undergoing it.

So, we thought, well, adolescents have real problems with sleeping. There's low stigma associated with insomnia, so it's a way of kind of, by stealth, getting into the mental health. There's a lot of uptake. Parents are really keen to have their kids sleep better and so you end up by having an app like that developed and put on the phone.

Q. Can I talk to you about implementation in school. What is the really promising thing about being able to implement live in a school?
A. We have a captive audience, we have all the kids usually - not all the kids, but a lot of kids. In one part of the program the kids are actually screened for mental health risk, including a question on suicide ideation, and we have a duty of care around the counsellor and the GP within that school region, and so, all kids who screen at risk are actually followed up by the counsellor.

Interestingly, although a lot of these kids are already known to the counsellor, there's a sort of like a silent group that nobody's really noticed. So, by providing them with the opportunity, if you like, to indicate that they might be at risk, we can then begin to offer help to them.

Q. Does that occur in the context of you running clinical trials, or do you roll it out on a whole-school basis when the app has already been proven, or both?
A. So, certainly in our clinical trials we have duty of care, but we have another program called Smooth Sailing which we're trying to run out now which does that in

concert with the school counsellor and the GP, and that's all automated as well. So, the kids get on, they get screened, and then they have the option themselves of choosing the sort of program they'd like to do and it's done in the classroom.

Q. So, do they, for example, spend an hour a week all doing the program at the same time, or is it individualised?
A. Depends on the program and how we run it. So, Sleep Ninja we did out-of-school hours, but most of them, if they're part of the curriculum - and often schools will agree that what we've developed as a resource is something that's useful for the curriculum and fits the curriculum and so it will be done within a PDHD class.

Q. How do you go about getting consent for the kids to participate in these trials when they are trials?
A. We approach the school and then usually in conjunction with the school we have access to the kids to invite them to be part of the project, and at the same time we have access to the parents. A big trial that we're just starting, we've done all the consent for this, it's only 14 schools but it's about to start on Monday so it's at the top of my mind. Around about 70 per cent of kids and their parents will agree to do the project.

Q. How have you gone with dealing with the Education Department in New South Wales, has that been a positive for you?
A. It's been a very positive experience. We've had a lot of support from them, and we have a very good relationship with them. Because, apart from the trials that we do and, as I said in the statement, we have a lot of exposure to schools, our programs are generally valued, I think Black Dog has a high trust component, and so, as a general rule we do get invited by schools many, many times to come in and deliver a particular program: whether it's volunteers talking to their kids, whether it's around mental health literacy, whether it's about suicide prevention. So, our engagement with schools is very good at very high levels in schools as well.

Q. We talked about effectiveness earlier on at a very general level, these types of programs being as effective as medication, can you say a little bit more about the effectiveness of these programs that you've rolled out in

schools in Australia?
A. Yeah. So, for example, one of the school programs which use SPARX was done a couple of years ago and we thought kids before their Higher School Certificate are stressed out, their parents are stressed out too, but the kids are particularly stressed out. So, we thought if we put the program in place six months before they do their Higher School Certificate, will it actually help them at the time they do the certificate. So, we found it resulted in around a 20 per cent reduction in depression symptoms by, if you like, immunising the kids before they actually got to the Higher School Certificate exam.

Q. Can you tell the Commissioners about iBobbly, what it is and how it evolved?
A. Yeah, so iBobbly is an app that was co-designed in an indigenous community in Broome. It was a fantastic project to be involved in, there was so much enthusiasm from the people involved.

We developed this app. What our contribution was, was to formalise what acceptance commitment therapy is, which is a form of like CBT in effective psychological intervention, and their role was to make the app something that indigenous young people would want to use. We used indigenous voices, male and female, it was culturally appropriate, we used artists from the region and so on.

We ended up with this app called iBobbly and we gave it to 61 young people within the Broome community, all over actually; long, long way. There's actually a nice photo of a picture of the app being used in a ute with a dingo so it was kind of very, very out there. We found that it resulted in a 42 per cent reduction in depression and a 28 per cent reduction in suicide ideation; that it was well accepted by the community, and that the drop-out rate was 3 per cent.

Q. Has that been rolled out further?
A. No. We've done a second trial of around 400 young people around Australia. At present we're trying to seek roll out from the Federal Government for it.

Q. Where would you like to roll it out? How widespread would you like that to be?
A. Across Australia. We realise that part of what we have developed skills in is implementation, and it's not

just a question of dropping it into the internet space; you have to work with all the organisations on the ground that know the community in which you're working. So, Aboriginal medical services, sports clubs, Men's Sheds, you know, the whole group of people on the ground who have access to the community, and we work with them in order to provide a structure, if you like, for these things to be known about and used.

Q. What features of that intervention made it particularly effective?
A. It was co-designed, it was done in conjunction with the local suicide prevention agency called Alive and Kicking Goals. When people saw it, indigenous people saw it, they knew it was designed for them.

And, you know, we have a lot of qualitative data saying what they actually said about it and, you know, they said things like, "This app, him deadly" and, you know, really, really showing that for them this was something that they used. Because they do use a lot of social media and technology, and we designed the app so that you didn't have to have internet in order for it to work: you could do it off-line and then the data was uploaded later.

Q. For suicide prevention, how significant is it that the intervention is delivered by way of an app?
A. Well, an app is one part of the picture. So, if you think about the effective strategies that are required for suicide prevention, I think the best way to describe it from our perspective was that we did have this centre for research excellence in suicide prevention that focused on technology.

We then got a big grant from the Ramsay Foundation, Paul Ramsay Foundation, in order to do a full implementation across four sites in New South Wales, and at that point we realised that the technology is the key to being able to scale effective strategies. So, it's not really about the apps themselves, it's how you employ them within a bigger scheme about what can be done across the intervention space.

Q. When you say "scale", do you mean enabling the intervention to reach a large number of people in a short period of time?
A. Yes. One of the things, say, about suicide prevention

is that, we cannot predict who will die by a suicide. We have to cast a large net, we can't just focus on particular people who might have risk factors. We have to say, we must spread this across the whole community, so a universal prevention, and then that requires that you engage the community and that everybody has a place and is aligned in a way for a coherent approach to it.

Q. Can I ask you a bit more about the suicide prevention systems that Black Dog is involved in. You've mentioned in your statement that Black Dog has developed a suicide prevention intelligence system. What is that?
A. Yes. So, what we found was that, we needed to evaluate whether our large-scale intervention was going to be effective, and we found that it wasn't very easy to get the research data that you needed: so Coroner's deaths, ambulance data, police data, hospitalisations, they all have a place to play in being able to provide you with the information of what's actually happening on the ground.

So, we developed this system which brings together all of those datasets and geospatially maps it into a local area, so we can see where deaths occur, where the risk areas are, where the hot spots are. We also bring in data about health professionals, so we can say where there's a missing group of health professionals within certain geographical areas.

It also allowed us, by bringing all this data together, to start to think about what other things people need on the ground to solve suicide. We developed what we call Suicide Audits which is, if you like, the intelligence that comes from the data to be able to assist. So, for some people in certain councils or areas, they weren't aware of where people were dying, so we were able to provide information about particular areas.

We were also able to provide information about what could be done, what are the strategies that you can do to, say, reduce deaths near cliffs or so on. That was delivered directly to the suicide prevention agencies or groups who were working on the ground in various primary health care networks.

So, I guess it's a mixture of having worked very hard to bring data together in a way that had never been done before, and then to use it in a way to try and answer the

questions that people on the ground had, which is where are people dying, who can help, has something just happened, though we do have trouble finding timely data.

Q. So, am I right in thinking that a fundamental plank of that strategy is that it's place-based, and that it uses data about a number of things that intersect in relation to the place; is that right?
A. So, the actual data system allows us to provide good information to the community. The life-span project brings together nine strategies to hopefully bring around some sort of synergy, because just doing one thing alone, that just doesn't have enough impact.

Q. Can we stay with the data in the place-based strategy for a moment. How is that rolled out? You mentioned the primary health care networks before, so can you perhaps give us an example of how this application would work in a local area through a Primary Health Care Network?
A. I guess I'm just making a distinction here between what I call our high fidelity trials and the --

Q. I see. Okay.
A. So essentially, we would commission a particular Primary Health Care Network, or Local Health District, to undertake a number of activities that we had suggested were required. We would then fund suicide prevention coordinators to work with collaboratives or other suicide networks already, and then we would provide as much possibly that we could in terms of the resources needed: so, how do you do aftercare? What sort of programs should you be doing in schools? Here's a media strategy and so on. And then that collective would work on the implementation of that particular strategy.

Q. I see, and you would use the nine strategies that you've set out in your statement, including by auditing what's going on in that geographical region?
A. Yes.

Q. And what resources are available in coordinating them?
A. Yeah. I think it's partly top-down, bottom-up, because you want to encourage the take-up within the community itself. So, one of the strategies is means restriction, which means making sure people are safer than they were. And so, the audits are around that particular strategy.

Q. I see.
A. Another strategy is making sure people get evidence-based treatment. We know 60 per cent of people who are in need of treatment do not receive it, so we then worked with the technology system in primary care where the person is screened by an app when they come into a primary care - or a GP surgery, and that information is then given to the general practitioner.

So, rather than the person going in and coming in saying I've got a mental health problem or I'm suicidal, it provides an opportunity for the GP to raise with them, how are you feeling? So, I think we put so much emphasis on help-seeking, rather than providing the context in which people can seek help, and so, this stepped care intervention is sort of a technology-assisted way of providing the opportunity for people to get treatment through their general practitioner.

Q. Of the nine strategies you've listed, is your view that they're all important equally, or that some are more important than others?
A. So, we actually wrote a short paper on this where we tried to estimate what the impact of these particular strategies would be based on a combination of the size of the effect that would be produced by each of those strategies and the extent to which we could get reach, so it really depends on how you look at it. If you can get really good reach, even with an ineffective strategy, you're going to end up with a pretty good result.

So, when we looked at suicide deaths the key ones were: means restriction, gatekeeper training and getting people into treatment.

Q. With your system, how do people acquire the system or apply it in their local area, and through whom does that happen?
A. So, we have a set of guiding principles about who the information should be sent to and under what circumstances, because obviously people need really to be trained to be able to get the statistics.

So, in our model, the people who are our suicide prevention people get that information, and then they share it through their networks with health professionals and so

on.

Q. And what - go ahead, sorry.
A. I was going to say, it is a problem. Like, we all have these suicide datasets that are kind of locked up and not integrated. So, we're doing our best, but yeah, there really is a difficulty in getting timely data to people on the ground.

Q. What's been the rate of uptake of the system?
A. Well, we started using the Paul Ramsay donation. We've added another site, which was the ACT, which is paying for us to do the actual site because we've spent all the money on the other four sites, and now the kind of general model of LifeSpan is being used in 29 sites across Australia.

And, it's not all those nine strategies, but I think what it's done is provide an overarching blueprint of what are the sorts of things that people should be doing in their communities.

We had a recent meeting in Canberra and brought together all the coordinators from these 29 sites, and it was really quite inspiring for me to see that people were doing different things, but they all felt that they had some direction about what it is that they were trying to do.

Q. What's the general geographical reach of a region?
A. So, for the high fidelity sites, it varies from 150,000 to about 300,000. So, the actual sites for the full trial are around about 850,000.

Q. And that's the population measure?
A. M'mm.

Q. Can you clarify what's a high fidelity site?
A. Okay, so the high fidelity sites are the ones in which we've had the Paul Ramsay Foundation. So, we have coordinators that we pay basically. The way it worked was that we put out expressions of interest to Primary Health Care Networks or Local Health Districts, and they then applied to be able to undertake the program. So, there was a lot of buy-in and enthusiasm.

Q. What have you found out about its effectiveness so

far?
A. Well, we haven't found anything about effectiveness, because our first set of sites, which were Newcastle and Illawarra, are just coming to the end of their two-year period now, and we have set up an evaluation strategy that requires that we have to wait till the end of all of those trials before we actually do the full-on evaluation.

We used what's called a randomised step care wedge design, a stepped wedge design, which essentially means that, of the four sites initially that we had, we randomised them to a particular order in which they received the LifeSpan intervention, and that allows us to determine whether there's a causal relationship between what we're doing and change in suicide rates.

Because, you know, if you just look at what happens when you intervene at one particular point, there could be a lot of other factors that intervene, so it's really we're comparing them to each other.

Q. So they perform control groups for each other?
A. Yes, and also, we of course have all the data from the rest of the areas as well which can also form a second level of control.

Q. Thank you. Can I ask you about digital phenotyping?
A. Yes.

Q. What is it?
A. It's been called the "new science of behaviour", which is a lot of hype. But essentially we do have signals that can be collected from our mobile phones which can be used to describe certain sorts of behaviour, or can be used, parsed and evaluated to see if they're related to particular forms of behaviour or to different mental states.

So, essentially, digital phenotyping is really a science at the moment, so what we're trying to do is validate whether any of the signals from your mobile phone will correlate with, say, mood. The goal of it is to provide more timely care or to help people who might be becoming unwell, recognise that they might be becoming unwell and be able to seek help or even sharing it with clinicians or other people.

Q. What are the signals that can be detected by the mobile phone?
A. There's many signals that can be detected, but in our particular view, we collect location data, accelerometry, so activity. We collect data on swipe speed, so typing speed or swiping speed, and we also can use it to collect audio voice signals in response to cues. We can detect/self-report as well by asking people questions directly, and yes, that's pretty much what we do.

We don't do anything to do with social media, Facebook, Instagram, Snapchat, any of those sorts of things, so it's very specific kinds of signals.

Q. What do those signals reveal about a person's mental state?
A. Well, that's the question and that's why we're doing the research.

Q. What's the hypothesis then?
A. We do know certain things: for example, we know that people who are depressed stay at home more and are less active.

But the real key question is, for an individual, can you tell that they're becoming depressed? Because that's just a general group difference, and we want to actually be able to tell at an individual level, is there something that those signals in combination are able to tell us about how that person's going? Or even tell the person themselves, not just us.

Q. I was just about to ask you that. Who gets the information and how is it used?
A. So, at the moment we get the information at Black Dog.

Q. So, is that on the basis of consent by participants in a trial?
A. Yes. So, for example, the trial that's starting next week, we have consent from both the parents and the children about that data being collected. We also allow them the opportunity to say what sort of data they're comfortable providing to us. So, they can opt out, for example, the location data.

With the location data in terms of privacy, we have it so that we only get it as an average over seven days at the

moment, so we can at no point tell where that kid is at a particular point.

Q. This is very much cutting-edge science, would you say, in this field?
A. Yes.

Q. So, why is Black Dog pursuing it? What potential do you see in it?
A. Well, I think Black Dog is a medical research institute, we're very interested in important questions like, can you predict suicide? That's essentially what motivates us to do it.

Also, in Australia we have a lot of trust, so people are prepared to give us data. We have a very high quality science leadership in this area as well, so it's really important to ask that. If people are going to be using these signals, they're meaningful, and that, you know, you're not getting people ripping people off or, you know, there's an authenticity about actually putting it under the microscope, putting it through human ethics, making sure everyone's consented, and that makes it something that we really would like to do and do well.

Q. Just back on how those kinds of signals would be used, do you need a third party to interpret the signals? Is that how the model would work?
A. Yes. You need more than a third party really. You need - it's sort of like this huge volume of data comes and how meaningful it is or what particular aspect of it is meaningful is really essentially not that well-known, because people don't use it in a standardised way. It's been done, but with very small samples.

So, when you have large samples, then you employ artificial intelligence to be able to help. We're actually take it two ways: one is artificial intelligence, so we're working with our partners at Deakin University with de-identified data to see if there's anything that can be pulled up from those signals when a machine does it as opposed to a human.

Then we're looking at the science of it by saying things like, well, when people are depressed, they slow down, and so, is there something in a rapid change in their speed of doing a particular thing that indicates to us

something more meaningful than, they're asleep? So, we're actually looking at, what are the types of signals would we expect to change and doing the analysis that way; the artificial intelligence is a parallel route that we're taking.

Q. Do you know what the length of time will be until you start to get some meaningful results out of this project?
A. Well, certainly over the next six months we'll have enough data to be really doing the artificial intelligence side of it. But this is - to me, it's like DNA. It took a long time for DNA signals to be made interpretable, and this is just really the beginning of the same process.

Q. On a slightly different form of technology, you've said in your statement that Black Dog's currently working on a project that uses CCTV with artificial intelligence to analyse behaviour in relation to suicide risk. What's that project and how does it work?
A. This really arose from the idea that, I went to a visit to - not that it's entirely my idea, I don't want to give that impression - but I went to Rose Bay Police Station and we were given a tour of the Gap Park which has a high incidence of deaths. They do have CCTV footage, but that CCTV footage isn't used until after the event, and it's actually only turned on when a person goes across the fence.

So, meanwhile they are still filming all the time, if you know what I mean, around the park, it's just not being looked at. So we have a partnership with Deakin University and there's lot of AI in surveillance in, say, airports and picking up anti-social behaviour - not that I'm trying to make a comparison between suicide and anti-social behaviour - but for example, what the technology's based on is seeking anomalies, so what is normal and what isn't.

And so, if you think about the Gap Park, there will be some people who might have anomalous behaviour, and whether that is somehow going to help us know that person is a particular risk; you know, whether it's something like maybe pacing or just sitting there and not doing anything for hours.

I think there was interest from the police and the Waverley Council. We tested the idea with consumers to see whether they thought this was, you know, a reasonable thing

to be doing, and at this stage we've now got a new technology partner and we will be starting to do that because we have a unique set of CCTV footage of events at the Gap Park from the police.

Q. So, would that inform two things: both potentially intervention when someone is perhaps contemplating suicide if the data is made available in real-time, and also, perhaps interventions by preventing means at particular sites?
A. I think that's the idea, that we want to see whether at least it is possible to get earlier to a person who might be at risk.

Q. So, you would have to link the data up with the means of providing immediate support?
A. Oh, yes, and, you know, if you know anything of the Gap Park, there's a lot of people at the Gap Park. There's often a lot of emergencies. I'm not sure of the exact number, but every two or three days there would be an emergency at the Gap Park, so people are very aware that it is a hot spot for intervention.

Q. Can you tell the Commissioners, please, what is RAFT, a digital app that you're trialling to deliver help after a suicide attempt?
A. So RAFT is developed by Mark Larsen at Black Dog Institute, it's a very short intervention. It's both a safety planning app that also offers intervention, psychological intervention, and we deliver it to people who want to participate in the research in a number of hospitals around Australia. So, they sign up to have RAFT and we're just evaluating whether RAFT does improve their mental health and does prevent them from making a re-attempt.

Q. Can I ask you a more high level question? What's your view about the extent to which we in Australia know much about the effective means to prevent suicide?
A. So, really a very big question. I think that the overseas experience shows that we're all struggling with this. I think the World Health Organisation, European Alliance Against Depression, have pretty much come up with a similar kind of view on it based on evidence that you really need to put all these strategies together: it has to be both health, it has to be social and support, and to ignore the community is really - or the public health side

of it, is not going to deliver the outcomes that you need.

We do know that a lot of broad factors are extremely important. I think this is well-known, that unemployment, a 1 per cent increase in unemployment results in a 0.07 per cent increase in suicide. We know from retrospective hospital data that, if you have more strategies in place from a hospital perspective in terms of outreach and so on, then you're more likely to get a better outcome for those particular district hospitals, so I think we do know enough to be able to be doing a lot in the space.

One of the most interesting - not interesting, but one of the most dramatic things that I think we've learned recently, is that, talking about suicide in a celebrity, or 13 Reasons Why, does result in an increase in suicide rate. So, there's been two recent papers showing that, for example, Robyn Williams' death, there was an 8.9 per cent increase in male deaths for the next two or three months in the US as a result of modelling which, you know, modelled expected death rates and then death rates after his death. I think it was August, for the next two months there was an increase.

And 13 Reasons Why, again, they looked at the expected effects on youth suicide, and there was an increase particularly in young men or young boys, as a result of that particular intervention. So, from a public health perspective I really think we have to be very, very strong in being able to not have these things, and to be able to act on them: I mean, that is a big effect, 10 per cent, something we almost dream of being able to achieve in a year.

Q. Is there research about the kind of counter-interventions that can be effective when something happens that is unplanned and can't be controlled by, say, having media guidelines because it just has occurred and is known about?
A. That's a really good question, I don't know.

Q. Is that something that's worth some research, do you think?
A. Yes, I think that's really interesting to see. I mean, we do know how kind of trauma can be handled in different communities and so on, but with that social media

it's a very interesting kind of area to work in. And, whether you can use social media to actually lower suicide rates is a question that we've tried to look at, but it's very hard to actually look at that scientifically.

Q. Can I ask you about a different topic and that is technology and e-Health. What's your view about the effectiveness of it and the utility of using it in Australia at its current status?
A. I think it's highly effective. In the trials that we run it's highly effective. The question is, does it transfer into the wild?

Q. In the?
A. Into the wild, into the world. And I think that's something that does need particular attention. But to me, it seems that there's a relative negativity around e-Health and technology, much more in Australia than in other countries where it's been embraced, and where it's been introduced into health care systems quite readily.

For example, in the Netherlands and in Sweden where it's similarly classed as something like Medicare, or you know, it's just part of the system and this is what you can get. Even in the UK now, I think through the IAPT, which is a process of getting psychological help to people through the trusts, e-Health is beginning to have some more impact. It's always been regarded as one of the inventions, but it is actually starting to really pick up.

The advantage of technology is not just that it could be as effective especially in that blended way I talked about before, but because of its scalability. So, for people who can't have access, when there's no health professionals, then automated CBT is highly effective. But we don't seem to have converted this knowledge into something that is just part of how we provide health services now, and I think that's a real shame, and I think there's probably not enough attention to it and there's not enough support for industry to really embrace it and put financial dollars behind it.

So, we still have, if you like - I wouldn't say a cottage industry because I think that a lot of the apps that we have have quite a large range, but in the health system it just doesn't seem to be picking up.

Q. What are the particular barriers to implementation?
A. It depends on the setting. So, in general practice I would say that GPs are used to doing it in a particular way, it's easier to refer people to a psychologist, rather than to an e-Health program. There's no incentive for them to do it. There's the time pressure, there's the difficulties in actually providing it directly to the people. The technology can sometimes be very clunky, it's hard to get people to invest in having this in the console of the GP.

So, I think in general practice it's around the way we've structured general practice. In the internet, directly through the internet we have a number of different providers. I think people think that internet interventions are just free. In fact, they require updating all the time, all the software needs to be improved, so there's no kind of investment in that that I see. So, I think there's lot of different sorts of barriers.

I think there's also an attitude that it's not good enough, that it's inferior to other interventions. I've heard people with lived experience saying that all the apps are hopeless and so on and so forth. So, I think that part of the problem is us, and there are a lot of not so great apps out there, but there's also this expectation that, if it's an app, it has to be slick. Rather than, if it's a health intervention, it's a completely different perception of what your expectation is from a particular technology solution.

Q. Is there anything else you'd like to say that we haven't addressed about the importance of digital interventions in preventing mental illness?
A. Obviously, I think it's the way to scale. I think the Health and Safety Commissioner's looking at it at the moment in terms of, how do we make sure that we get high quality products? I think that's about it, thanks.

MS NICHOLS: Thank you, Professor. Chair, are there any questions from the Commissioners?

CHAIR: Professor McSherry.

COMMISSIONER McSHERRY: Q. Thank you very much for your evidence today and for your comprehensive statement. I

just wanted to raise perhaps a potential barrier for the take-up of these interventions.

We know that personal health information has been referred to as some of the most sensitive data. So, do you think there might be a barrier in terms of privacy issues?

Certainly we saw with My Health Record a number of people with lived experience decided to opt out because they were concerned about third parties perhaps accessing information. How do you go about combatting that perception or that barrier in reality?

A. Thank you. One of the projects we have is a project called Living Labs, and we try and explore the way in which people want their health information used, and we find that people are happy to share their health information under different conditions.

So, I really think ultimately it's going to come down to people owning their health record so that they have control over it. On the other hand, we don't get too much negativity from schools, or from workplaces where we are introducing some of this app technology, so I think people are quite willing to do it if it possibly isn't in the health system and possibly if they're convinced that they're giving the data to a trusted organisation that knows how to look after it.

Q. The other question I have: I know in the criminal justice field there's been some concern about algorithms that are used for risk assessment tools, that they may be racially or culturally biased. So, I'm interested in the AI side of things: how do you protect against sometimes unintentional bias in the risk assessment tools that you're developing in terms of children who may be at risk of depression, for example?

A. I think it is a really big issue. I think people are investigating, as you would know, the different biases that are involved in AI. You know, it's a question of generalisability as well. Like, if we're talking about children of a particular age, then really we can only talk about algorithms that are related to those particular children who are of that particular gender of that particular composition, so I think the whole issue of, once you go past the generalisation of what you're doing with your AI, then you start to get into much bigger problems.

Ultimately, it comes down to the samples that you do select, and that there should really be compensation or differences in the types of samples that are used to develop these algorithms so that they're much closer to the population distribution characteristics.

Q. Just a final question too. I think that some consumers with lived experience might be concerned about what happens after the screening or surveillance, that there might be a perception that coercive measures would be taken to, you know, force the person into treatment or into compulsory care. How do you guard against that?
A. I'm not sure how you guard against it in the public arena where you've got commercial - that you're putting out, but certainly it's at the forefront of our mind when we seek consent and we seek ethics, to make sure that we're totally out there about what the privacy considerations are, what the consent is, what our governance is, what the technical requirements are that are needed to make these things safe.

So, for example, all of the apps and so on that we use are only used in Australia, we only use data from Australia. They're kept on a UNSW servers. They're encrypted, and so on and so forth. So, I think that it all comes down to people with lived experience being involved in what data they want to share, how they want data used, who owns their data, and I really believe that ultimately we're going to have consumers owning their own data, or people owning their own data, which I think is the way it has to go.

COMMISSIONER McSHERRY: Thank you very much.

CHAIR: Q. Thank you, Professor. I just have two other issues I'd like to clarify. The first one is in terms of your apps and who you are trialling them with and using them with.

We've learnt a lot in this Royal Commission, and it's been raised about the importance of early intervention and the growing prevalence of mental health issues in younger children. In terms of the work that you've done to date, how age-specific is it in terms of the interventions through the schools, for example? So, that's the first issue.
A. Yes. So, you've got this balance between screen time

and apps of course, and how young you want kids on screens. All our work at the moment is in adolescents, so the youngest would be around 13, or 12 to 13. One of our positive psychology online programs, Fight Back, is designed for 12 to 14-year-olds.

You know, it depends on what kind of condition you're talking about. So, for example, autism and so on, I think there's something to be said about providing opportunities for kids to use apps or online programs, or machines, with autism because they seem to learn and it's something that they relate to. So, you don't want to make too much of an age - should be this particular age or not.

Q. Thank you. I also noticed with the work that you were talking about doing on suicide prevention, you talked about the three things that you'd found to be very important was about means, restriction, gate-keeping, training and getting people into treatment.

Can I just confirm what you think is the effective treatment that you would be advocating there? Is it CBT like you have been talking about earlier in terms of the apps or a broader range of treatments?
A. I think it's a broader range of treatments. Certainly CBT is effective but DBT, Dialectic Behaviour Therapy, is much more commonly used and the treatment is effective, but I would be recommending in treatment people get proper assessment by a psychiatrist, physical health assessment, the whole range; it wouldn't just be an app with CBT on it.

We have, though, just finished a meta-analysis of apps that are used in suicide prevention, stand-alone ones, and we've found that they are effective. This is from something like 16 studies around the world we've actually looked at. If people use these apps from these trials, do they actually have some benefit? Most of those apps use CBT.

CHAIR: Thank you very much, Professor, and thank you very much for your very comprehensive statement and your evidence today.

MS NICHOLS: May I tender that statement, please? I missed doing that. [WIT.0001.0062.0001]

CHAIR: Yes.

MS NICHOLS: And, may Professor Christensen be excused?

CHAIR: Yes, thanks Professor.

<**THE WITNESS WITHDREW**

AT 3.26PM THE COMMISSION WAS ADJOURNED TO MONDAY, 22 JULY 2019 AT 10.00AM

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