

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

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

7
8 In considering that, the Commission's inquiry's not
9 limited to looking at the clinical system or the mental
10 health system as it may conventionally be understood.
11 Community resilience can be a protective factor; it may be
12 important for young people, marginalised communities, or
13 those collectively facing a crisis. You will hear evidence
14 about each of these areas.

15
16 During community consultations, the importance of
17 building resilience and promoting good mental health was a
18 common theme. Factors that negatively impact community
19 mental health were identified, including financial
20 stressors, social isolation and loneliness.

21
22 Bullying, particularly online bullying, as well as
23 stigma and discrimination, particularly for minority
24 groups, were also identified as negatively impacting
25 community mental health.

26
27 There were also several programs and services that
28 were identified as contributing positively to community
29 mental health. For example, Men's Sheds, community houses,
30 community arts programs, sporting clubs, youth mentors and
31 volunteering opportunities. What these programs have in
32 common is that they provide a safe space that fosters
33 social connectedness and a dialogue.

34
35 Through submissions, the Commission heard that people
36 are disconnected from each other. There needs to be an
37 increase in ways people get together.

38
39 In the course of the evidence today there will be a
40 focus on innovative or novel ideas, including the way
41 technology can be used to promote community resilience.

42
43 You will hear from Greg McMahon, who is the Executive
44 Principal of Hallam Senior College and the Strategic
45 Director of Doveton College. He has been an educator for
46 37 years. Mr McMahon will speak about his experience
47 supporting the mental health of young people at school and

1 implementing programs at school relating to the mental
2 health of young people, but also supporting the broader
3 community.
4

5 Mr McMahon has a particular experience in programs
6 known as Our Place at Doveton College and the
7 implementation of the Berry Street Education Model.
8

9 You will hear from Emma King, the Chief Executive
10 Officer of the Victorian Council of Social Service, or
11 VCOSS. In the context of her professional experience,
12 Ms King will address why certain communities in Victoria
13 have or are at greater risk of having poor mental health,
14 including the impact of socio-economic status and
15 disadvantage.
16

17 Ms King will address the importance of early
18 intervention and what might be done to ensure efforts are
19 responsive to the Victorian community, including examples
20 of interlinked, well connected and coordinated services.
21

22 Matiu Bush is the Founder of One Good Street and
23 Deputy Director of the Health Transformation Lab at RMIT.
24 One Good Street is a neighbourhood social networking site
25 that aims to reduce loneliness and isolation in older
26 people. He will talk about One Good Street and what it
27 does and also other technological measures that promote
28 connectedness for older people, all the while bearing in
29 mind that face-to-face contact is where real connectedness
30 lies.
31

32 Jane Anderson is a Latrobe Health Advocate, a role
33 which provides independent advice to the Victorian
34 Government on behalf of Latrobe Valley communities on
35 system and policy issues affecting their health and
36 wellbeing. It was a role established in response to the
37 Hazelwood Mine Fire Inquiries. In her evidence she will
38 address the resilience her community has demonstrated.
39

40 Ms Anderson will also convey the experience of the
41 Latrobe Valley community in relation to mental health, with
42 a focus on how certain interventions in the Latrobe Valley
43 might also be effective in other places in Victoria.
44

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

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

5
6 Professor Christensen will set out Black Dog's
7 research programs, how it undertakes randomised control
8 trials, how it applies the results of those trials and how,
9 in particular, it implements interventions in schools.
10 Professor Christensen has particular expertise in e-Mental
11 health and will describe a number of innovative programs
12 which the Black Dog Institute is delivering by way of
13 electronic platforms.

14
15 I propose to call the first witness now. I call Greg
16 McMahon.

17
18 **<GREG MCMAHON, affirmed and examined: [10.08am]**

19
20 MS COGHLAN: Q. Mr McMahon, you've provided a statement
21 to the Royal Commission?

22 A. I did.

23
24 Q. I tender that statement. [WIT.0003.0008.0001] You are
25 the Executive Principal of Hallam Senior College?

26 A. That's correct.

27
28 Q. You are also the Senior Director at Doveton College?

29 A. Correct.

30
31 Q. You were the Executive Principal at Doveton College
32 from 2014-2019?

33 A. Correct.

34
35 Q. You've been an educator for 37 years?

36 A. A long time.

37
38 Q. Focusing on your time at Doveton College as the
39 principal, but also as the Strategic Director now, can you
40 just explain what your role is as Strategic Director?

41 A. A Strategic Director is building on the relationship
42 between the school and all what we'd call the wrap-around
43 services. So, if you go back to what we all went through,
44 you had a school that opened at 9 o'clock and closed at
45 3.30. But at Doveton it's not that: we open at 7 in the
46 morning, we close late at night. Within the school
47 environment we have a community hub, if you like, that has

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

7
8 Q. In terms of Doveton College itself, it opened in 2012?

9 A. The first full implementation was 2013 but it opened
10 at 2012, yes, but they added on another element in the
11 next year.

12
13 Q. It opened in response to the closure of four local
14 schools in the area?

15 A. At one stage Doveton itself had six, but at that stage
16 it was down to four, and they therefore closed and one
17 school was built. It was part of the regeneration program
18 within Victoria; similar things happened in Broadmeadows,
19 for instance.

20
21 Q. When was the model called Our Place first adopted?

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

30
31 Q. I'll come to ask you about Our Place model at Doveton,
32 but I'll just ask you about this first. One other model,
33 if you like, that was implemented in 2015 was the Berry
34 Street Education Model?

35 A. Correct.

36
37 Q. I'll ask you more about that later. So, you've talked
38 about what Doveton College does differently to other
39 schools. Can I just take you to a particular passage in
40 your statement and then ask you about it. You say at
41 paragraph 13?

42 A.

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

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

9
10 In a place like Doveton that could never work because
11 what you had was parents who had never been successful at
12 school, or were off boats, out of Manus Island, places like
13 that. So we had significant disadvantage. The barrier to
14 entry for these people was the front door. And so we as a
15 community said we have to reshape what that's about.

16
17 Research said, in Toronto and in places like England,
18 things had to change if you're going to change the
19 opportunities for disadvantaged communities. And so, this
20 is Julius Colman's philosophy, implemented by June
21 McLoughlin, Shannon, and the team out there of the Our
22 Place team.

23
24 So if you look at it, it's a place-based initiative,
25 the school is the place. It is taking disadvantaged
26 communities where the postcode has determined outcomes. If
27 you go back to the Jesuit 2015 study, you'll see those
28 postcodes have never shifted: Doveton's always been in, if
29 you like, the league ladder of disadvantage.

30
31 What the school became was the community centre, it
32 was the add-on hubs that were built around it, and it's not
33 a significant build. It became the centre of, if you like,
34 what we would see as the opportunities for children,
35 families and communities to flourish because they had the
36 opportunities and they had the confidence to come into it.

37
38 And it was built around these five components: high
39 quality schools - non-negotiable; high quality Early
40 Learning and the Early Years wrap-around services such as
41 Maternal and Child Health, Play Groups; out-of-school,
42 after school activities for young people, and I'll give you
43 an example: when I first got to Doveton, 7 per cent of
44 young people did anything after hours, 7 per cent.

45
46 Now, my parents were taxi drivers, took us to sport,
47 music, everything. My previous school at Parkdale,

1 basically kids did everything after hours, middle-class
2 aspirants, but they, 7 per cent. By bringing in after
3 school opportunities we've got it to nearly 70 to
4 80 per cent of take-up.

5
6 Then you had, for instance, all the wrap-around health
7 and wellbeing services that were required, both allied
8 health and health, and then you had the Adult Learning
9 Volunteer Programs and After School Men and Women of
10 Doveton Programs, so it's a whole range of things being
11 added on to the central spoke, if you like, of the school.
12

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

16 A. Yes.

17
18 Q. And that includes a paediatrician?

19 A. It does. I'll give you the rationale behind it.
20 Young people have to be school ready, and school ready
21 means they can't walk in with a back pack of disadvantage
22 on their back if they're going to have an opportunity to
23 learn, but many of our kids did, up to 50 per cent. And
24 so, one of those big issues was diagnosis, understanding
25 what were the issues behind them: it could have been
26 cognitive, it could have been social/emotional, it could
27 have been physical, it could have just been a cultural
28 issue.
29

30 So, when we saw the number of students, and when I
31 arrived at Doveton there were about 15 students on the
32 program for disabilities, and when I looked around I'm
33 saying, this can't be right, but there was no diagnosis of
34 it. Our parents would not go to paediatricians. Why? You
35 have to book in, there was a gap in payments, you had to
36 travel, there are all these barriers.
37

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

1
2 The big advantage is, the parents do not need to go
3 anywhere, they come to a place they're comfortable in, the
4 school, and it's organised by my wellbeing team led by
5 Amara Miles.
6

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

12 A. Yes.
13

14 Q. In addition to that, you've got social workers and
15 psychologists actually directly employed by the school?

16 A. Yes, we operate four within our team, but if you like
17 there's the department team as well, what's called the
18 SSSO. We have a speech pathologist and a psychologist
19 there; two days a week for the psychologist and one day a
20 week, speech pathologist. Then we have the Monash Health
21 who have a community need to be out in the community and
22 what they do is provide other services for us; we provide
23 the location and the clientele.
24

25 Q. You say in your statement that Doveton College has 650
26 students?

27 A. Yes, well, that varies every day, I can guarantee you,
28 we enrol every day.
29

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

31 A. Correct.
32

33 Q. And you have 75 children, roughly, in your Early
34 Learning Centre?

35 A. At any day, 110 over the week, yep.
36

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

39 A. Yes.
40

41 Q. Can you elaborate on that?

42 A. Yes, so if you walk into Doveton the first thing
43 you'll walk into is a welcoming environment, so the
44 receptionist, two receptionists, one of our receptionists
45 speaks seven languages, so straight away one of the
46 barriers of communication is broken down. Within that we
47 have a coffee lounge and we have our engagement officers

1 from the Our Place team, two of them.

2

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

8

9 Q. CV.

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

14

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

22

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

27

28 "We have a diverse and often vulnerable
29 student population."

30

31 A. Yes.

32

33 Q. Can you expand on that a little bit more?

34 A. Okay, within Doveton you've got a number of
35 components, the school component is 650 young people from
36 prep through to Year 9, then you've got your Early Learning
37 component, then you've got your wrap-around services.

38

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

46

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

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

7
8 The Department of Human Services are basically at the
9 school everyday for some reason: whether it's case
10 management or picking up clients or other things. At any
11 time we will have somewhere between 20 and 30 in
12 out-of-home care, and these are young people less than
13 15 years old, so some of them have never been with their
14 parents. So, yes, really significant trauma and
15 disadvantage and complex, very complex.

16
17 Q. One of the things you mentioned was the idea of, I
18 think you've said, a higher level of mobility?

19 A. Yes.

20
21 Q. And that's because it's a high rental zone?

22 A. Yes.

23
24 Q. So that you have people enrolling and then unenrolling
25 frequently?

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

36
37 Q. I said I'll come back to the idea of the Our Place
38 model at Doveton. You've talked about that being a
39 place-based initiative of the Colman Foundation, and you
40 work in partnership with DET at 10 selected sites across
41 Victoria - not you personally, but there is that
42 partnership.

43 A. Indeed.

44
45 Q. And there are a number of other sites at which Our
46 Place is currently being implemented?

47 A. Yes. So, Doveton was the first and out of that came

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

12
13 Q. And Officer?

14 A. Officer, Cardinia, yes, so all of those are the sites
15 that are in progress of being either developed or have been
16 developed.

17
18 Q. You've mentioned a couple of times about the idea of
19 the hub of the community and that, from your point of view,
20 is really what Our Place at Doveton is, that the school is
21 the hub of the community?

22 A. Yes, it is the hub of the community. It is the place
23 where people have confidence and feel that they can cross
24 the threshold into a school, and not only a school but all
25 those things that are added onto the school.

26
27 If you think about this: the school is the first thing
28 to open in a community, it is the last thing to close
29 before a community ceases: nothing else. They don't put a
30 police station there first, a school will open, and in that
31 sense that's why it's the most important thing. It is the
32 common thing for everyone within a community. Sooner or
33 later, if they've got kids, will go to school somewhere and
34 it's in that community that we've then built these other
35 allied health and add-ons, if you like.

36
37 Q. I'm going to ask now for a video to be played and I'll
38 ask you some questions arising from that.
39 [WIT.0003.0008.2000]

40
41 (Video played.)

42
43 And so, that video was really a day in the life of the
44 school?

45 A. Yes.

46
47 Q. I've just got a slide up now and I just want to ask

1 you about this. [WIT.0003.0008.1000] This is the
2 essential core principles for the operation of the school.
3 I want to ask you about them, perhaps working clockwise
4 from "A Single Entrance". You've already spoken about that
5 in terms of the way it welcomes people in?

6 A. Yes, absolutely, that's soft entry, that really
7 welcoming entry.
8

9 Q. What about, moving on from that, "One Story, One
10 Time"?

11 A. One of the greatest barriers for any parents who have
12 come through, certainly trauma, is that they are asked to
13 tell their story, repeat their story over and over again to
14 different organisations, different services, and ultimately
15 they get sick of it. And so, as a college, as a community
16 hub, we've basically taken on the idea that we never turn a
17 person away, we'll always make sure that they can enrol at
18 that time, or there's an appropriate time where we're both
19 happy for that to occur.
20

21 But at that enrolment for instance, it's not just one
22 person, we bring in our wellbeing team, we bring in all our
23 service team to make sure we have covered all elements so
24 you don't need to go back for another enrolment, and
25 another enrolment.
26

27 But we ask the question to the family enrolling,
28 you've got the young people there, okay, that's a school,
29 because they think they're enrolling at a school. By the
30 time they've walked out, often mum's enrolled in adult
31 learning or sewing class or play group, the youngest ones
32 may have enrolled in Early Learning, we may have got them
33 into some of the other services if they indicate that they
34 need those. So, it is that One Story, One Time, it is the
35 idea that the community team is such an important one to
36 ensure that they feel comfortable and they've got a link
37 back to the school, that critical person that they know and
38 feel comfortable coming to talk to.
39

40 Q. Moving on then, what about: "High Quality, Explicit
41 Teaching - Birth Onwards."
42

43 A. If you look at the results at Doveton back in
44 2012-2013 when it first opening, nearly 50 per cent of kids
45 in the Naplan testing were so far behind. Young people,
46 education is their key to be able to move into something
47 better in life, otherwise we've just got generational

1 poverty over and over again.

2

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

13

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

19

20 Q. There's also a focus on quality in infrastructure?

21 A. Infrastructure. It's quality everything. So, it's
22 the quality in terms of relationships, the infrastructure,
23 the pedagogy that we use, the resources we build into the
24 young people, the programs that we set up and the
25 opportunities that are given to not only the young people
26 but their whole family.

27

28 Q. Moving on then to referrals. You say here that, warm
29 and formal to integrated health services?

30 A. So, if a barrier to entry - and I'll use my economics
31 background here - a barrier to entry is basically an
32 ability to access a service, and that service says you have
33 to book online, but I don't have a computer at home -
34 there's a barrier. Or I have to speak English because they
35 won't understand my language - there's another barrier. Or
36 I have to get into a car and travel but I haven't got a
37 car, therefore I have to use public transport. Those are
38 all barriers. One of the things we looked at was how do we
39 break down those barriers to ensure, if you like, an
40 immediate access to services.

41

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

1 across and talk to the Maternal and Child Nurse, come
2 across and talk to the allied health. We may have to come
3 back a bit later but you'll have met hem.
4

5 So, soft referrals is building that confidence in
6 people to know that they're going to get an outcome in a
7 timeframe that they're really comfortable with.
8

9 Q. You've already touched on adult education but you also
10 refer to the volunteer program in these essential core
11 principles?

12 A. Yeah, so the adult learning is essential. We know
13 that mums are the greatest drivers of educational
14 opportunities for young people. I wish it was dads, I wish
15 I could say that. But mums are the ones predominantly in
16 the care of the young people, and in our case, because
17 there are a lot of single parents, they're predominantly
18 mums. So, we saw that, if we can upskill the parent body
19 in both formal and informal education, they see education
20 therefore as important: if I'm doing it, their kids are
21 going to be doing it.
22

23 One of our great success stories, multiple success
24 stories, is a parent who now works at the college, and when
25 she saw this, she had left school I think at the end of
26 Year 9, had a young one there, and she would say she had a
27 pretty traumatic background. She was quite cynical at the
28 start about the whole thing, but she did a short course,
29 Creating Capable Leaders it was called. She did that, a
30 bit cynical, but our engagement team sat down and worked
31 with her.
32

33 She then went on to School Council President, did her
34 course, did a Certificate III, is now working at the school
35 in a caring role in the classroom. So things like that
36 just make a huge difference. As she said, I'm studying at
37 home, and her daughter, who's at school, is a ripper, she
38 sits beside her, she's told, get on with your reading, get
39 on with your homework. That wouldn't have happened in the
40 past.
41

42 So by being able to get the parents to break down the
43 barrier of education so they see it as important, then it
44 flows through to the young people.
45

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

1 philanthropy?

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

15
16 The Neighbourhood House provides a lot of the funding
17 for the adult learning, and we provide an RTO as a third
18 party, BRACE, who come in and deliver. There's a small
19 amount that comes back into the school, we put that into a
20 person who's basically a childcare worker for the day,
21 because our Afghani mums who want to learn English won't
22 leave their kids anywhere. So, they come in, they have
23 them in the classroom with them but a person looks after
24 them.

25
26 Q. You've already talked about the extended day in terms
27 of after school activities, are there other aspects to that
28 extended day?

29 A. Yes, there is. You would have seen at the start the
30 basketball program. Our young indigenous - we've got about
31 between 7-10 per cent Aboriginal and Torres Strait Islander
32 community, some of the most fantastic kids I've ever come
33 across, but huge trauma in that community as well.

34
35 In that community, we saw in about 2016 absenteeism
36 was massive. And so I talked to the person who runs the
37 Doveton Gathering Place, which is the Aboriginal Gathering
38 Place, Emma Thomas, and I said what can we do? She said we
39 need to find a way of getting these kids there. And I
40 said, "I know sport's the driver." She said, "Okay, I'll
41 organise it, you find the facility."

42
43 So, at 6.30 in the morning, 7 o'clock, they start. We
44 see our young Aboriginal people either being picked up or
45 running to the college to participate in basketball, and
46 it's got so big they've actually outgrown it, they're going
47 elsewhere to a bigger setting, but the kids are at school.

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

5
6 And the other one is the end of the day where I've got
7 our Men of Doveton and our Women of Doveton. The Men of
8 Doveton - interestingly, men don't have great
9 relationships, they just don't have many friends. We
10 opened this up through - we were getting word that a lot of
11 the community, men were just sitting at home if they were
12 unemployed, or had mental health issues or alcohol,
13 whatever it was.

14
15 Through the YMCA coming on board and through the other
16 services who had identified young men from the age of 18
17 right through, we set this program up. The first had 18
18 graduates. It is basically a 12-week program and is based
19 on the idea of the Sons of the West in Footscray, the
20 Western Bulldogs, who had set up a similar thing, and
21 theirs is massive. But it's all built around resilience
22 and it's built around the idea of building partnerships and
23 relationships, and these people are still in touch with
24 each other. Many of them have now come back to be the
25 mentors for the other groups going through.

26
27 Q. And that's not just parents, that's any members of the
28 community?

29 A. Any member of the community. And any member of the
30 community can use Doveton, so for instance the allied
31 health, Play Groups, et cetera.

32
33 Q. If we can just move to some of the key challenges that
34 are faced by Doveton College in delivering Our Place. One
35 of the things you mention in your statement is
36 institutional challenges.

37 A. Yeah, institutional challenges in the sense of, we set
38 up our institutions primarily for, I suppose, middle-class
39 people, and people who have confidence. So, myself,
40 there's no issue with services provided, I'm happy to get
41 on websites, myGov, whatever it is, but if you don't have a
42 computer, that's a real issue. And many of our parents -
43 only 70 per cent of our parents had access to a computer;
44 they had phones but that was it.

45
46 It's also the idea that the services often have a time
47 delay, you have to book in, you have to stay online, all

1 these sort of things, and those institutional things
2 basically took away from what we were trying to do because
3 what they did was put up a barrier in many cases.
4

5 So we had to find a way through that, and the way
6 through that was often to start talking about having soft
7 referrals, having things on site so we could do that. Or
8 more so if our engagement team at the college saw that
9 there was a need to go outside, were able to build the
10 confidence and even take people to those settings so they
11 had confidence, knew where to find them, and then from
12 there were able to make their own way later on. We're not
13 about - it's not a deficit model, it's a model of saying,
14 build the capacity and then they'll look after themselves,
15 they'll make great decisions.
16

17 Q. I asked you earlier about the Berry Street Education
18 Model, can I ask you some specific questions about that
19 now. Just first of all, what is it?

20 A. Berry Street Education Model is a model around social,
21 emotional competencies, but it's really developing the
22 understanding for teachers around trauma-enforced practice,
23 and it comes out of the work of the Berry Street Institute
24 based on some of the work in the US and has been
25 transformed into an Australian model.
26

27 So, it's really built around a number of different
28 aspects of what we do in the classroom; it is not something
29 that stands alone, it's everyday elements that we build in
30 around our language, our routines, the way we understand
31 young people, and the way we implement processes and
32 practices to support those people.
33

34 Q. You say in your statement that it was adopted at
35 Doveton College because we saw the need for our teachers to
36 be equipped to respond to the needs of children who had
37 experienced trauma?

38 A. Absolutely. I'll give you one example. If a young
39 person's come through domestic violence, and like any
40 community issue we have that at Doveton. The young
41 person's been yelled at all their life, they've seen
42 physical violence, and yet, many of our teachers who have
43 come from backgrounds in middle-class areas, they thought
44 if they raised their voice that was going to solve the
45 problem. Well, it didn't, because our young people either
46 fight or flight.
47

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

8
9 The one thing we've learnt at Doveton, like any
10 school, is that young people seek to have regularity, they
11 want processes, they want procedures, they want
12 understanding. They want to know where the boundaries are,
13 and Berry Street just gave us another level of boundaries
14 and also processes in terms of that language and processes
15 and procedures.

16
17 Q. One of the things you mentioned in your statement is:

18
19 "It's about teachers developing
20 understanding and having empathy for
21 children's experience of trauma and
22 providing teachers with strategies for
23 implementing a positive road forward."

24
25 A. Yes, absolutely it is, and it's been a huge change in
26 the culture and the climate of the classroom that we see.
27 And so, you don't teach Berry Street as such, you embed
28 Berry Street into your teaching.

29
30 Q. Can you give some examples of how that might be
31 embedded?

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

39
40 It is about the routines of lining up outside and
41 moving into the classroom, how you would set those up. It
42 is about the thing of positive regard for the young person.
43 What they've done in Berry Street is given us a language
44 and a process, what we would say is just great common
45 sense. Great common sense, but common sense is a rare
46 commodity in a whole lot of things in society. So, by
47 using this we've been able to provide a consistency of

1 approach across our college.

2

3 Q. In terms of the education that staff need or teachers
4 need to implement it, it's initially four days of training?

5 A. Yes, four days training from the Berry Street team, so
6 that was four came out for four days and we did that across
7 a year. So, that was late 2015 into 2016. And then we
8 have, if you like, a Berry Street mentor, a teacher, who
9 basically was in charge of Berry Street ensuring the
10 continuing implementation of professional development of
11 staff.

12

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

18

19 Q. So, you just mentioned there, it's not just teachers
20 it's the entire staff?

21 A. Yes, we've got nearly as many what we call ES,
22 Education Support workers, as we have teachers. So, there
23 are about 32, I think, Education Support workers at the
24 college, and again they have to be upskilled in Berry
25 Street because they're working with the young people
26 one-on-one, so that's really important.

27

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

29

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

34

35 Can you just elaborate on that?

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

43

44 Q. You've talked about it broadly in a teaching model or
45 an embedding model. Is there any kind of individualisation
46 for students in the way that things might be approached?

47 A. Oh, absolutely. Because one of the things would be

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

7
8 We say we're the most important person in their life
9 because we have them for about seven hours a day and often
10 they see us more than their parents. But at the same time
11 we have to understand what's going on outside, so what are
12 they walking in with? So as a result, we have to
13 differentiate the way we work with young people.
14 Everything can't be as consistent and rigid, but you want a
15 consistency of approach, if you like; within that you've
16 got differentiation.

17
18 Q. One of the things you mention in your statement is
19 that students have focus plans?

20 A. Yeah, focus plans, what they're working on in their
21 own development. It's like an individual learning plan in,
22 say, their literacy, the same thing with Berry Street: what
23 is the class working on and what is the young person
24 working on.

25
26 Q. In your experience, what benefits has that model
27 provided?

28 A. If you look at the statistics that are coming out from
29 Doveton in terms of engagement, so the Department of
30 Education does a student survey every year. Back in
31 2013/14, the outcomes across learning confidence,
32 engagement, relationships, all the areas that they test
33 were in the bottom quartile at year, say, 7-9.

34
35 By 2017, they were in the top quartile. So, what
36 we're seeing is engaged young people. Our attendance now
37 hits state averages. Now, it wasn't that, it was mid-80s,
38 so we're at about 92, 93 per cent, slightly lower in one
39 area, but slightly higher in the other. They're just
40 fantastic outcomes. You can't have young people developing
41 if they're not at school, so in that sense school becomes
42 the consistent, and then what we're doing in the school
43 becomes the icing on the cake, it really does.

44
45 MS COGHLAN: Thank you, Mr McMahon. Chair, do the
46 Commissioners have any questions?
47

1 CHAIR: Dr Cockram.

2

3 COMMISSIONER COCKRAM: Q. Thank you for the really
4 interesting work that's being undertaken. In the last,
5 particularly yesterday, we heard a lot about the importance
6 of communication with families and individuals, and
7 particularly around language. I think you mentioned
8 there's 52?

9 A. Every day changes, yes, but a significant number,
10 yeah.

11

12 Q. How to you manage the language issues both within the
13 school and within the hub?

14 A. Okay. A great question, because effectively that was
15 one of the barriers. For instance, front desk: Lima, who's
16 one of my receptionists; seven languages, all the Afghani,
17 Middle Eastern languages, and a significant number of our
18 people are from that background, so automatically where do
19 they head as soon as they walk in? Over to Lima.

20

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

27

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

31

32 Q. If I can just extend that question. So, if a family
33 is in the hub having some parenting sessions or seeing
34 someone, would the interpreter come from out of the
35 workforce within the school, or would you bring in
36 interpreters?

37 A. Depends. Depends if we've got that on site. If we've
38 got that on site we'll go and get those people straight
39 away. To give you an example: one of the great barriers
40 was parent-teacher night. We've all been to parent-teacher
41 night, we've all loved them where you get five minutes of
42 hearing about your young person.

43

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

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

11
12 COMMISSIONER COCKRAM: Thank you very much.
13

14 CHAIR: Q. Thank you, Mr McMahon, for your comprehensive
15 statement and for your evidence today. Can I just ask, and
16 for those children or young person or the families where
17 you have concerns about their mental health and wellbeing,
18 how does the service respond to those concerns?

19 A. Okay, so the first thing is identifying what that is,
20 and that can be quite obvious or become lack of being
21 obvious. We've got an exceptional wellbeing team, and they
22 will meet in a whole lot of different ways.
23

24 So, to give you an example: what we've done there is,
25 Amara Miles who leads that, we have referrals into that
26 group, they meet on a regular basis, they will look at all
27 the young people and then they'll work out an action plan:
28 is that something we can internally deal with or is it
29 something we have to go outside to? We have all those
30 different services that we can access. So, that is all
31 done through that team.
32

33 One of the other things we've brought in is case
34 management, and so, for instance we will on - might be a
35 Wednesday morning now - the team, let's say it's a Grade 3,
36 they will pick out three or four young people who we've got
37 concerns about: might be cognitive, might be social,
38 emotional, whatever - and they will - 15 minutes we really
39 target those young people and say, what's the issue, what
40 do we need to do about it, what are the outcomes we're
41 looking for? And so that becomes an action plan.
42

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

1 especially a secondary teacher like myself from economics -
2 woeful. But in that sense that's why the support around us
3 is so important, we need to know what we need to do.
4

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

14 A. Okay. So, transition, we've got a number of points of
15 transition: one is from Early Learning into the school, one
16 is from the school at Grade 6 into Year 7, and the other
17 one is from Year 9 through to what we call Year 10, 11, 12.
18

19 The Early Learning transition is really important and
20 that's where the team of Early Learning and the school work
21 together. I mean, our young people at Early Learning know
22 the school backwards, they're in there every day, they're
23 part of our assembly so that's not a huge issue. Joining
24 the pedagogy is a challenge at the moment, because you go
25 from a play-based to a far more explicit, but we're working
26 on that.
27

28 What we have to do at Year 6 is to ensure that the
29 young people want to stay at Doveton because they have to
30 make a decision to transfer to a senior setting at some
31 stage, that's either at the end of grade 6 or the end of
32 Year 9, and so we've worked really hard on that, that's why
33 the after school programs and everything have been so
34 successful in supporting the young people, and we not only
35 hold them now, we add.
36

37 Then at Year 9 the issues becomes, where do you go
38 next? Building aspirations, and while we've supporting
39 these young people we've also challenged them, challenged
40 them to have high aspirations. They don't want to be
41 lawyers and doctors, we know that that's not going to
42 occur.
43

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

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

3
4 CHAIR: Thank you very much.

5
6 MS COGHLAN: Thank you, Chair, may Mr McMahon be excused?

7
8 CHAIR: Yes, thank you for your evidence, Mr McMahon.

9
10 <THE WITNESS WITHDREW

11
12 MS NICHOLS: Commissioners, the next witness is Emma King,
13 I call her now.

14
15 <EMMA JANE KING, affirmed and examined: [10.56am]

16
17 MS NICHOLS: Q. Ms King, are you the Chief Executive
18 Officer of the Victorian Council of Social Services?

19 A. Yes, I am.

20
21 Q. Are you also the Chair of the Future Social Service
22 Institute and an Associate of the School of Global Urban
23 and Social Studies at RMIT?

24 A. Yes, that's correct.

25
26 Q. With the assistance of the Royal Commission, have you
27 prepared a witness statement about the questions we've
28 asked you to address?

29 A. That's correct.

30
31 Q. I tender the statement. [WIT.0001.0061.0001]
32 Ms King, can I ask you firstly to tell the Commissioners
33 briefly about what the Victorian Council Of Social
34 Services, or VCOSS, is and what are its aims?

35 A. Thank you. VCOSS is a peak body in the community and
36 social service sector. We work to eliminate poverty and
37 disadvantage and to give every Victorian a good life. We
38 do that through our policy and our advocacy work, looking
39 to really influence the way that government develops its
40 policies and shapes its priorities, as I said, with the aim
41 of giving every Victorian a good life.

42
43 Q. You're a peak body, so how do the organisations that
44 you represent engage with the mental health system?

45 A. In terms of being a peak body, we represent a broad
46 raft, our members are a broad raft of the social sector.
47 So, including very small community or volunteer-run

1 organisations, through to very big organisations such as
2 Anglicare, Berry Street, MacKillop Family Services,
3 et cetera, as well.
4

5 We look at the broader ecosystem when it comes to
6 community services, so looking at, for example,
7 neighbourhood houses, looking at justice and legal
8 services, drop-in centres, early childhood services,
9 et cetera, so there's a very broad raft of services that
10 actually make up our broader ecosystem. And basically,
11 wherever you are in a community you'll be able to touch one
12 of those services, so they often have a very strong role in
13 terms of preventing or early intervention in terms of
14 mental health services, as well as more directly engaging
15 in the other side of the mental health system, if you like,
16 as well.
17

18 Q. Yes, so a number of the member organisations would
19 engage in the protective factors for mental wellbeing?

20 A. Very much so. So, if you look, for example, at the
21 community health services, they very much engage in the
22 protective factors - as do the others that I mentioned,
23 looking at neighbourhood houses and others as well - very
24 much in terms of looking at protective factors.
25

26 So, if I was to draw on neighbourhood houses as a
27 particular example, looking at one that I'm directly very
28 involved with, whether people come into touch with that
29 local neighbourhood house by virtue of the fact that they
30 have a community garden, that they have a cooking class for
31 people with special needs.
32

33 Q. I'll ask you to slow down a little bit. Keep going.

34 A. So there's many different ways, if you like, that it's
35 kind of a soft entry point for any member of the community
36 to become involved with that neighbourhood house.
37

38 Q. I see. In your experience, are there particular parts
39 of the Victorian community who are, by dint of their social
40 and economic circumstances, much more likely to be at risk
41 of developing mental illness?

42 A. Absolutely. When we look at people who are in
43 poverty, the reality is, they are far more at risk in terms
44 of developing mental health. So, we know overall that at
45 least a third of people who are in poverty have severe
46 mental health issues. I would suggest that that's an
47 underestimate for the reason that they're people who have

1 been diagnosed.

2

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

10

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

22

23 Q. Would you say that disadvantage and mental ill-health
24 reinforce one another?

25 A. They most certainly do. So, in terms of looking at
26 how any member of our community can look at how they can
27 access general services, so whether that comes to looking
28 at housing, whether it comes to financial assistance, no
29 matter what it may come to, but the reality is, for people
30 who are struggling to get a roof over their head and
31 somewhere that's actually safe, affordable and appropriate
32 to live, whether they're choosing between whether they put
33 food on the table or turn the lights on or turn the heater
34 on in winter or the air conditioner on in summer, they're
35 very real choices that we see people make.

36

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

47

1 Q. What do you say, on the basis of your experience,
2 about the sufficiency of social security payments like the
3 Disability Support Pension and Newstart to help people who
4 may be experiencing mental ill-health to start to reach
5 towards recovery?

6 A. They're woefully inadequate. The notion that someone
7 can survive on less than \$40 a day and be able to meet
8 their living expenses, it's simply not possible. We've
9 seen support for increasing the amount of Newstart come
10 from across the broader political spectrum, and the reality
11 is, if you're poor, if you're trying to survive on less
12 than \$40 a day, all of the studies, the Anglicare Rental
13 Affordability study, others show that it's just simply not
14 possible to be able to access appropriate housing
15 throughout the whole of Victoria.

16
17 We also know through the poverty atlas research that
18 we undertook and is available on our website, there is not
19 one single corner of Victoria that is untouched by poverty.
20 So, in terms of looking at the inextricable link between
21 poverty, and simply the lack of support that is in place
22 that helps people to access services; that of course goes
23 further than the pure income component alone, it goes to
24 whether you can afford a car or whether you can actually
25 access transport to get from wherever you may happen to
26 live to be able to access services, whether you can afford
27 a phone in the first place.

28
29 For any of us who have tried to access NBN or the
30 internet lately, we would know that the only way you can
31 communicate is actually via an online service, so if you
32 don't have one in the first place, your chance of doing
33 that is impossible. What I would say is, even today,
34 walking down to the Royal Commission, we walked past two
35 people who are literally homelessness and in sleeping bags
36 on the street. It's profound and it's staring us in the
37 face.

38
39 Q. Can I ask you about the impact of holistic support
40 provided in the community on helping people deal with
41 mental ill-health and move towards recovery. There's an
42 example that you've provided in your witness statement of a
43 young woman called Amy. Would you like to tell the
44 Commissioners about her?

45 A. Yes. Amy is not her real name. Amy was in a
46 situation of significant family violence and left the
47 relationship with literally the clothes on her back.

1 Obviously, as a consequence she had no financial support
2 whatsoever, she had suicidal ideation, she was really at
3 the depths of despair, would be how I would describe it.
4

5 She approached Star Health, a community health
6 organisation. Star were able to provide significant
7 assistance to Amy. They were able to assist her in
8 connecting up with services that went to looking at
9 housing, connecting up to organisations that could assist
10 her with putting food on the table, with clothing, with a
11 whole lot of other issues as well.
12

13 It was that real - the part about actually connecting
14 up and not saying, we're only going to deal with one part
15 of that situation that you're dealing with in isolation, we
16 understand that we actually need to join the dots in
17 looking at how we do that and doing it in a very practical
18 way.
19

20 Amy's case is quite profound for the reason that it
21 shows, for someone who was at the absolute depths of
22 despair and her mental health and therefore her physical
23 health, et cetera, was in extreme danger, through the
24 assistance that Star Health provided, not only was Amy able
25 to have some stable accommodation provided and other
26 assistance provided, she was able to then enrol in a law
27 degree at university.
28

29 So, she went from a point of absolute despair to being
30 able to achieve something which had been a dream of hers.
31 So, it shows that when we can build partnerships up,
32 et cetera, we can deliver enormous differences for people
33 and look at their broader - not only the living day-to-day,
34 but their broader wellbeing and actually help them achieve
35 the opportunities that they should have and they deserve.
36

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

38
39 "We need a whole-of-government approach to
40 preventing mental illness and building
41 resilient communities."
42

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

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

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

3
4 In terms of looking at the five key priorities that
5 New Zealand has and then the 60 indicators, we think we
6 could move quite significantly from our current process of
7 the way that we approach budgets, which are about
8 fundamentally economic inputs, and look very differently in
9 terms of saying, how do we do that in terms of wellbeing?
10 So how do we look at the wellbeing of every single
11 Victorian, how do we deliver on that front?

12
13 So, economics is only one part of the job of
14 government, and we know that economics alone doesn't
15 deliver a good life for Victoria. So, for example, at the
16 moment you could argue that Victoria has a very strong
17 economy, but yet you have the parallel of saying, we're in
18 a housing crisis, we've got 82,000 people who are
19 languishing on a public housing waiting list.

20
21 So drawing on the model of New Zealand which has
22 prioritised mental health, it's prioritised children in
23 terms of the wellbeing lens that it has as an overlay,
24 along with a host of other things that particularly impact
25 on people in poverty, including looking at the climate, the
26 environment, et cetera, as well.

27
28 So I would argue very strongly for moving from the
29 current way that we undertake our budget, to looking at a
30 budget that is a wellbeing budget and having that lens
31 across that more broadly as well.

32
33 Q. Is a key element of a wellbeing budget approach to
34 value other things than a purely economic measure of how
35 well society is doing?

36 A. That's correct, it's about putting people first, and
37 if we've going to look at how we put - in terms of looking
38 at putting a wellbeing budget in place, if we measure
39 outcomes by actually what are the outcomes for people
40 rather than looking at it purely through an economic lens,
41 it's a much - I think it's an eminently sensible way to
42 approach this.

43
44 The economic lens - and New Zealand has - there's a
45 lot of commentary around this, around saying that, if you
46 look at it purely from an economic point of view, it
47 doesn't capture the people who are left behind. We know

1 that there's a significant amount of inequity within our
2 society more generally: it's a really sensible, sound,
3 robust way to say, let's actually look at how we do our
4 budgets and do them differently, rather than through the
5 pure sort of output measures that we look at at the moment.
6

7 Q. You've also said in your statement that "place-based
8 responses empower local communities". Can you say what you
9 mean by "place-based responses" and then I'm going to ask
10 you about how they empower communities and why?

11 A. Certainly. And I feel quite privileged actually to
12 come on after the principal of Doveton Community College
13 and I've had the good fortune to visit there on a number of
14 occasions and they're just outstanding in the work they do
15 and a perfect example of place-based communities, and I
16 know the Commission has visited Maryborough and we've been
17 fortunate to be involved with Go Goldfields along the way
18 as well, and being invited to sit at their tables has been
19 an absolute privilege.
20

21 When I talk about place-based there are a number of
22 key indicators that are really important as part of that.
23 One is in terms of being genuinely place-based, so
24 genuinely embedded in community and tailored to the local
25 community however that might be defined, and that will look
26 different in different places. So, it's not taking a
27 cookie-cutter model and looking at one size fits all.
28

29 It's having flexible funding so that the local
30 community can determine what are the key elements that they
31 want to change within their local community, and Go
32 Goldfields is a perfect example of that, where they looked
33 at the key indicators that they wanted to shift in their
34 local community but having an evaluation process in place.
35

36 Q. I'll ask you about Go Goldfields in a moment, but
37 getting to flexible funding, in what respect does it have
38 to be flexible?

39 A. It needs to be flexible for the reason that, if you
40 can look at what the key indicators are that you want to
41 change in your local community, quite often funding from
42 departments, to be frank, it can be quite micromanaged and
43 it's designed to deliver a particular outcome or a
44 particular output.
45

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

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

10
11 Q. I might ask you now to talk about Go Goldfields,
12 firstly by saying what it is?

13 A. Yes, so, Go Goldfields is a place-based initiative,
14 it's placed in Maryborough. I know the Commission is aware
15 of this having been there this week, equidistant between
16 Ballarat and Bendigo. One of the challenges I think
17 Maryborough has had as a community is in terms of looking
18 at somewhere that - and I want to be careful how I describe
19 this, because in working with local community members, one
20 of the things they talk about is, they don't want to be
21 defined by a deficit model, they don't want to be defined
22 by the disadvantage, even though there's significant
23 disadvantage that exists within the community and it's
24 significantly poor.

25
26 They want to look at the strengths that they have in
27 terms of a community and the fact that there's a huge
28 amount of voluntarism for example. There's a huge amount
29 of local leadership.

30
31 It's through that local leadership that they were able
32 to define, I think, fundamentally pitch to government a
33 very effective model about the things that they wanted to
34 change within their community. They wanted to reduce the
35 number of children who were referred to child protection,
36 they wanted to increase the literacy and numeracy within
37 their community, they wanted to increase the employment
38 levels within their local community.

39
40 They've been able to show on their key indicators, and
41 this is evidence that's been undertaken through Murdoch,
42 that they were able to shift on the key indicators that
43 they all chose. When you go to the local
44 community, irrespective of whether you speak to the
45 maternal and child health nurse, just someone from the
46 police, just someone from the hospital, to the school, to
47 the local business, the president of the football club who

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

5
6 One of the other things they do, and an example of
7 this would be in their approach around family violence,
8 when they developed their approach around working to
9 eliminate family violence within their community, they put
10 out a call in the local community to ask women who were
11 victims of family violence to come forward. They had over
12 30 women in a local community come forward to contribute to
13 that strategy, but one of the deal breakers for them as has
14 been reported to me is that they said, we don't want to be
15 victims, we're experts. And we'll sit around the table and
16 we'll help you work out a strategy going forward.

17
18 It was a privilege, I was asked to launch that and to
19 launch their policy, and it was incredibly emotional and
20 really profound to have that at that launch a large number
21 of women who have lived experience of family violence,
22 standing alongside representatives from council, local
23 business, the football club, the school representatives,
24 basically the whole community and it was the whole
25 community's business and that's how you make change.

26
27 Q. Do you know how Go Goldfields got started?

28 A. Go Goldfields got started because they pitched to the
29 government. I think, to be frank, the money was delivered
30 slightly just before an election date, but they pitched
31 basically after quite a lot of community work saying these
32 are the key indicators that we want to change in our
33 community.

34
35 When you look at the Dropping Off the Edge report,
36 that Jesuit Social Services drives, Maryborough was always
37 in the top five communities for the wrong reasons: it was
38 always considered a community of abject poverty and
39 disadvantage, but yet you had a local community who said we
40 know this can change, we can take ownership and we can help
41 deliver that change but you have to let us do that at a
42 local community level, rather than having people coming in
43 from outside and imposing ideas that over time were proven
44 to not work.

45
46 So it was around saying, look, we've tried a whole lot
47 of other things, but they haven't worked, what can we do,

1 what can we do that's different?

2

3 Q. In relation to the question of funding, can I ask you
4 to say some things about the NDIS. Firstly, in the wake of
5 the NDIS's introduction, what's been your experience about
6 pricing and the barriers it can create to accessing
7 services?

8 A. Pricing is a significant issue when it comes to the
9 NDIS. So, in terms of looking at the price that is
10 provided to deliver a service, it's significantly beneath
11 the actual cost of providing a service. So, what that
12 means, so I don't think we'll find anyone who's going to
13 argue against choice and control as envisaged within the
14 NDIS. However, there's a perverse sort of thing happening
15 at the same time, where by virtue of providing a funding
16 model that is less than the cost of delivering a service, I
17 would argue that it's not being set up for success.

18

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

24

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

32

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

39

40 Q. So your concern is about the sustainability of the
41 sector that provides services that the NDIS is intended to
42 fund?

43 A. That's correct, it is about that. There's a couple of
44 other points I would raise in addition to that. One is,
45 keeping in mind with this being the Royal Commission into
46 Mental Health, that it was never intended by the NDIS to
47 actually cover many people who have mental health issues.

1
2 So, it was really, if you look at the forecast, it was
3 about 10 per cent of people who have severe mental health
4 issues that NDIS was set up to service and establish.

5
6 So, if we look at people with severe mental health
7 issues, that means there's about 135,000 Victorians who are
8 going to be left behind.

9
10 Now, there is some transitional funding that's been
11 provided by the Victorian Government for a two-year period.
12 And when I say 135,000, I'm talking about people with
13 severe mental illness and I'm talking about what I believe
14 is an underestimate, because we know a number of people who
15 have mental health issues are not diagnosed, particularly,
16 as I mentioned earlier, people in poverty who may not be
17 able to access services in the first place.

18
19 Then we have a whole group of additional people who
20 don't necessarily meet that severe diagnosis who might have
21 episodic mental illness. The NDIS is not designed for them
22 at all. So, we have a huge gap when it comes to NDIS and
23 mental health services because it is a system that was not
24 really set up to deliver services to people who have mental
25 health issues in the very first place.

26
27 Q. Have you had any experiences of any other difficulties
28 that people with severe mental health issues have accessing
29 services?

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

38
39 It shouldn't be an either/or proposition, but often
40 for people to be able to access any assistance it's only
41 possible to get that assistance very much at the tertiary
42 end. So, your health has to have deteriorated to such a
43 significant extent before you can get the assistance that
44 you need.

45
46 So we know, for example, that half of all people
47 diagnosed with a mental illness, that mental illness has

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

10
11 In terms of, if we're going to re-imagine our mental
12 health system, and we were to look at the broader ecosystem
13 of community-based mental health services and the other
14 ecosystem that exists within our community, I think if we
15 were to look at what we want our system to look like, how
16 do we use all of the components of our community to
17 actually deliver prevention, early intervention, and to
18 help people early rather than saying we're simply not going
19 to give you any support until you get to the tertiary end.

20
21 Q. Can I return to a subject you mentioned earlier and
22 that is homelessness. You have proposed that Victoria has
23 a statewide discharge policy requiring no exits into
24 homelessness. Can you explain what you mean by that?

25 A. Yes. In terms of, we know for example at the moment -
26 as I said, homelessness is really profound when we're in a
27 housing crisis in Victoria - in terms of looking at what we
28 would argue should be a rapid re-housing type model, would
29 be for example if someone's currently in the justice system
30 or they're in hospital or they're in another environment,
31 the reality is a number of people are being - whether it be
32 hospital or justice system for example - they're being
33 discharged into a situation where they actually have
34 nowhere to go.

35
36 So, if you're being discharged from a hospital, but
37 you don't have anywhere safe to live afterwards, if you
38 don't have a mental health condition already, you're
39 probably going to develop one fairly quickly.

40
41 For people who are exiting our justice system, for
42 example, we know that many people are exiting and they have
43 absolutely nowhere to live; or, if they do, it's really
44 insecure and kind of questionable housing that I suspect
45 none of us would want to live in. So, it's really
46 critical.

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

8
9 So we believe that it's really important for anyone
10 who, wherever they are in our system, if they're being
11 discharged from a service, et cetera, they need to have
12 somewhere safe, affordable and appropriate to live. It's a
13 bit of a no-brainer, if you don't have somewhere safe to
14 live it's clearly going to have a significant impact on
15 your mental health immediately.

16
17 Q. Can you tell the Commissioners something about the
18 Doorways program that helps people find a home in the
19 private rental market?

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

28
29 It's that strong importance of looking at the
30 wrap-around services that also occur at the same time that
31 someone is being housed, and looking at the interaction
32 with the private rental market and the opportunities that
33 exist there, alongside looking at - so if we're looking at
34 public housing and social housing, but also looking at the
35 way that service providers, and in this case Wellways, work
36 with the private rental market and look to provide support
37 to people who require it in terms of the broad raft of
38 support of people who need it.

39
40 But making sure along those lines that we can access
41 the private rental market as well, because if we look at
42 affordable housing overall, it's a key part of our system
43 at the moment. We've got a huge long list when it comes to
44 public housing and when it comes to community housing as
45 well, so we need to look at how we can access our private
46 rental market which at the moment is extremely unaffordable
47 for most people, particularly obviously those who are in

1 poverty.

2

3 Q. One of the things you emphasise in your statement is
4 the need to have integrated and coordinated services about
5 which we've heard quite a great deal in this Commission.
6 The description you use is "partnerships". Is there a way
7 in which competitive tendering has the propensity to
8 undermine productive partnerships?

9 A. It most certainly does. Competitive tendering we've
10 seen work to the absolute disadvantage of the broader
11 community service system. Many of our services are put out
12 to public tendering. Within that context, a key example
13 would be within the alcohol and drug space, where five
14 years ago there was a significant re-tendering process that
15 took place.

16

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

26

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

33

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

44

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

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

6
7 Q. And so, are you suggesting that the criteria for
8 tenders need to be broader to accommodate the things you've
9 referred to?

10 A. They really do, because we know that we can achieve
11 the greatest outcome through partnerships. We know, in
12 terms of looking at how - the previous witness spoke about
13 having that common entry point, for example, so people not
14 having to tell their story multiple times: that's a really
15 critical component. Because if you're constantly having to
16 re-prosecute your story, we know that people just give up.

17
18 The other part is that there's a barrier after barrier
19 after barrier put in someone's way, so we need to be able
20 to take that away and, if we've got organisations that are
21 competing with each other, we're not enabling the process
22 for partnerships, and strong resilient partnerships that
23 will evolve beyond the relationships someone might have
24 with one key individual as well, but are actually stable
25 and there for the test of time.

26
27 Q. Can I ask you about some of the challenges in securing
28 a high quality workforce in the community sector?

29 A. There's a number of challenges about a high quality
30 workforce within the community sector, and one of the
31 things I would say overarching there is that, keeping in
32 mind that, according to ABS data, this is the fastest
33 growing area of the Australian workforce. So, when we look
34 at healthcare and social assistance, this area is growing
35 faster than any other area of the workforce, so it's
36 important to look at for a number of reasons.

37
38 These jobs are generally poorly paid, they're
39 precarious, highly casualised, and they're also highly
40 gendered, so they're generally held by women, and I don't
41 think they're particularly well valued by our community,
42 despite the fact that they provide critical services that
43 deliver the wellbeing of our community.

44
45 There's a couple of key points that I would also make
46 in addition to that. One is, when it comes to community
47 sector organisations in Victoria, they're indexed at

1 2 per cent per year. Now, we know that is below the award
2 cost of providing a worker in that sector. It's also below
3 the cost of providing a service in Victoria. When I
4 mention the cost of indexation, I don't mention it for the
5 point of one year only, this is a compounded effect. So,
6 for year after year after year in Victoria we have had
7 indexation rates that are well below the cost of delivering
8 a service.

9
10 One of the challenges we have in that space is the
11 lack of data. So, if I was to contrast that to our health
12 sector. If you were to go to a hospital, it's very easy to
13 get data on the workforce, it's very easy to get a common
14 dataset. You can look at the projections of what that
15 hospital will need, the age of people who are delivering
16 services, et cetera. We don't have that for the community
17 services sector.

18
19 To contrast that, in the health sector they receive a
20 much higher level of indexation that actually meets the
21 requirements of delivering the required service. We don't
22 have that in the community sector and instead we have years
23 of very low levels of indexation that don't meet the
24 requirements of actually paying someone their award or
25 agreement wage, let alone delivering the broader service
26 overall, so that's a key challenge that we have.

27
28 We also have one additional challenge which is that,
29 because we don't have enough workers in the system, with
30 the recommissioning that occurred, for example, within the
31 alcohol and drug space, we see workers leaving the sector
32 overall. Keeping in mind that, because this is one of the
33 highest growth sectors, there's a high degree of
34 competition between workers who are in the mental health
35 space, workers who are in family violence, the NDIS, early
36 childhood, these are all growing workforces, yet none of
37 them have particularly secure or well paid jobs.

38
39 So, there's a lot that can be done. A common dataset
40 I think would help us enormously in terms of having a very
41 strong evidence model around that and looking at how we can
42 look at much more secure funding towards these services
43 into the future, keeping in mind that none of these
44 services are going to be replaced by automation. They are
45 jobs that require people, they're jobs that require people
46 who are highly skilled at their jobs, we need to value them
47 and we need to look at this as a workforce for the future

1 because that's what it is.

2

3 Q. Thank you, Ms King. Are there any matters that you
4 would like to raise that I haven't asked you about?

5 A. I don't think so, thank you very much.

6

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

9

10 CHAIR: Professor Fels.

11

12 COMMISSIONER FELLS: Q. Thank you for your evidence. At
13 various points you talked about homelessness and the
14 broader questions of housing and accommodation. I just
15 wonder if you could give us your general take on public
16 housing and mental illness. How do you see the state of
17 public housing and its relationship to accommodation for
18 the mentally ill?

19 A. I think there's probably a number of different aspects
20 to that. Because I think one of the key parts is
21 accessibility in the first place. I think it's around
22 looking at also the connections that exist between people
23 who live in public house and being able to access services.
24 So it's probably, I'd say, depending on where someone
25 lives, they would have different experiences on that front
26 which could be worthy, I think, of further examination.

27

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

37

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

41

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

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

7
8 COMMISSIONER FELS: No, it was such a general question.

9
10 CHAIR: Q. Thank you very much, Ms King. There's one
11 other thing I wanted to ask you about, which is: in the
12 evidence we heard earlier about Doveton College and its
13 success, there was a contribution from a philanthropic
14 organisation, so over and above the contribution of
15 government, the contribution of different agencies, there
16 was a philanthropic organisation, and even in the example
17 you used of Go Goldfields, there was a high level of
18 volunteering and community contribution.

19
20 With this focus on place-based innovative models of
21 service design and delivery, how important do you think it
22 is for us to maintain that broader philanthropic volunteer
23 community contribution to service delivery?

24 A. Certainly. I think volunteerism is really important,
25 it's probably something that we often see quite clearly in
26 place and it becomes to part of belonging in community
27 contribution. I think there are a couple of things at
28 play. Obviously, looking at philanthropic support, that's
29 always going to be incredibly welcome, and what we tend to
30 see is that that allows a higher level of innovation than
31 government funds have traditionally enabled.

32
33 I do think that there is significant room for
34 government to look more broadly about how might there be
35 more flexibility and trust with the way that community uses
36 funds.

37
38 In that example I would go back to Go Goldfields and
39 say they had an evaluation model running throughout, so
40 it's not about saying, you know, here's money with no
41 accountability. We're watching communities - and Doveton
42 is another example - who want to be very accountable for
43 the money that they receive and look at actually how are
44 they measuring results and results of their community along
45 the way.

46
47 So I think the philanthropic money has been really

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

11
12 So we've argued for a social innovation fund that we
13 think could be provided by government to enable communities
14 to try some new things. Particularly when we look at
15 communities that are in, to be frank, abject poverty, that
16 have been for years, I would argue that multiple different
17 approaches have been tried with the very best of intent but
18 they haven't worked, and we've looked at communities that
19 really are ready to go with their own ideas, looking at how
20 they can do things differently.

21
22 We know they tend to get those ideas up when they talk
23 to philanthropy who are keen to back them. I think it
24 would be great to see government step up more to the plate
25 as well to say, well, actually what role can they play
26 without putting in - often they'll seek to put in
27 overarching backbone support from outside a local
28 community, which seems to me to defeat the purpose a bit.

29
30 Q. We've also heard throughout this Royal Commission and
31 at various times about the importance to break down social
32 isolation for people with mental health issues, and there's
33 often been commentary about the fact that now we no longer
34 have drop-in centres or day centres, and some of the
35 psychosocial supports that have been available in the past
36 seem to be diminishing. What is your reflection on that?

37 A. My reflection on that would probably go to some of the
38 comments I made earlier in terms of NDIS and other
39 services, where we've seen organisations, if you like, that
40 are not adequately funded to be able to provide the
41 services that they want to within local communities.

42
43 Another example would be looking at aged care, for
44 example, where previously organisations that received block
45 funding were able to spend more time with people who might
46 be lonely and in their homes; the fact that they had more
47 time to be able to spend with someone, to help them shower,

1 to help them do other things as well. And we know that now
2 those services are being cut back, so we're seeing
3 significant cutbacks being experienced across the board.
4

5 And, when it comes to - if I go back to where I opened
6 which was looking at neighbourhood houses as an example:
7 they're a beautiful example, I think, of where people can
8 come together without having to disclose mental health or
9 loneliness or all those sorts of things, because they're a
10 sort of a soft entry point where you might go to be part of
11 a community garden or a choir or a cooking class and
12 actually become part of your community.
13

14 So I think we really need to look at how do we invest
15 in our community, how do we invest in our broader community
16 ecosystem, because we know that, in doing that, that
17 actually deals with many of the issues we have around
18 isolation and loneliness.
19

20 In that example there is something key in mind for me,
21 and that is that at our local community neighbourhood
22 house, there is a gentleman who has schizophrenia, he is
23 regularly in and out of hospital but as soon as he's
24 discharged he comes into the neighbourhood house because
25 that's where he belongs. Everyone knows him, and we know
26 him very well, and he's a key part of the neighbourhood
27 house and his background was as a barista. Some days he
28 comes in and makes coffee for everyone. But it's the place
29 that he belongs and, as he describes, the neighbourhood
30 house saved his life.
31

32 COMMISSIONER COCKRAM: Q. You mentioned in your
33 statement about partnerships and we've discussed that a
34 little bit, but we've also heard throughout these hearings
35 consultations from Community Primary Care and a range of
36 people about the complexity in the number of people in the
37 NGO mental health space, if I could put it that way.
38

39 Has VCOSS got a way forward in relation to the
40 complexity of that service provision system? And, have you
41 got some suggestions for us to consider as part of that?

42 A. That's a great question. I think part of that also
43 comes down to the contracting or tendering out that's taken
44 place that's probably splintered the system to a degree as
45 well, so I think if we can look more at that partnership
46 model to begin, but also take the broader view around - I
47 do think there's that ecosystem that exists in terms of the

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

11
12 I think that one of the key parts around sometimes
13 looking at local community or place-based models, they're
14 often very good at working through that themselves where
15 they're genuinely and able to be place-based models, and if
16 you look at Doveton for example and all of the services
17 that are delivered not necessarily through Doveton but, as
18 they talked about with the partnerships they have with
19 other - whether it be local council, whether it be health
20 organisations, whether it be others - for the person who's
21 coming in accessing those services, the point is that
22 they're there rather than who are they accessing them from.

23
24 If you look at Go Goldfields and how they provide
25 services within the local community, the point is that
26 those services are there. I remember hearing one of the
27 local Maternal and Child Health nurses speaking to the
28 librarian around talking about encouraging a young mum to
29 take her kids to story time, and this mum, this is her
30 third child and she'd not been to story time beforehand.
31 So, thinking around actually how do we have conversations
32 with people about the services that exist for them, but how
33 do we try and join that up as a system rather than make
34 each an individual part and harder for people to navigate.
35 Because the reality at the moment is it's a system -
36 loosely termed "a system" - that is incredibly hard for
37 people to navigate and, to be frank, incredibly hard at
38 times to access.

39
40 I'm not sure if that, again, fully answered your
41 question.

42
43 Q. I guess the question has at its base, have we got too
44 many of these multiple agencies out there? And I guess
45 it's certainly making it hard for both - it sounds like in
46 the evidence we've heard - for GPs, for consumers, for
47 their families, about which one's delivering which bit, and

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

7
8 We know for example, looking at the energy space which
9 VCOSS has done a lot of work in, often the first place
10 people will present will be at their GP. But we know GPs
11 don't necessarily go through and say to someone: actually,
12 the reason you're presenting with a particular illness is
13 because you can't turn the heater on and you're cold and
14 there's a whole lot of other issues here.

15
16 So having a GP equipped to talk about, here are the
17 other local services that we can connect you up with, how
18 can we help you. Those sorts of things I think are really
19 pivotal. So, part of it is about information and looking
20 at, in a local area, actually how might you bring that
21 together so again it's easier to navigate.

22
23 I do think Doveton is a perfect example of that, where
24 it's actually looking at, not only the child, if you like,
25 that enters the Early Learning Centre or the school, but
26 actually the whole family, and it's a perfect example of a
27 place-based model that is really there to help people but
28 also might identify things that someone may not identify in
29 and of themselves, but to say, we've got this other
30 service. Again, it's that "how can I help you" approach
31 that means that people might be willing also to disclose
32 things that they may not feel free to disclose to people
33 otherwise.

34
35 COMMISSIONER COCKRAM: Thank you.

36
37 MS NICHOLS: May Ms King be excused, Commissioner?

38
39 CHAIR: Thank you very much. Thank you for your evidence
40 today.

41
42 MS NICHOLS: Chair, is it convenient to take a 15 minute
43 break?

44
45 CHAIR: Yes, thank you.

46
47 **SHORT ADJOURNMENT**

1
2 MS COGHLAN: The next witness to be called is Matiu Bush,
3 and I call him now.

4
5 **<MATIU ROGER BUSH, affirmed and examined: [12.06pm]**

6
7 MS COGHLAN: Q. Mr Bush, you've provided a statement
8 with the assistance of lawyers from the Commission?

9 A. Correct, yes.

10
11 Q. I tender that statement. [WIT.0001.0056.0001] You are
12 the founder of One Good Street?

13 A. Correct.

14
15 Q. Which is a social networking platform to encourage
16 neighbour-initiated care for older residents at risk of
17 social isolation and loneliness?

18 A. Correct.

19
20 Q. What's your other key role at the moment?

21 A. So, I'm the Deputy Director of the Health
22 Transformation Lab at RMIT University, and that lab is set
23 up to tackle health care's most wicked problems, our
24 thorniest problems, and that includes loneliness and
25 isolation.

26
27 Q. When did you start in that position?

28 A. July the 1st.

29
30 Q. What about your broader background; I guess, first of
31 all in relation to having a Masters degree in Public
32 Health?

33 A. Correct, so a Masters degree in Public Health, a nurse
34 practitioner and have been involved in health care for
35 about 25 years. So, I've had clinical experience in
36 emergency departments, ICU, oncology, outpatient
37 department, elective surgery wait list, so I feel that I
38 have a broad lens or a broad view on the health care
39 system.

40
41 Q. Can I just ask you a bit more about One Good Street.
42 Can you tell the Commissioners what that is?

43 A. Absolutely. So, One Good Street's a network or a
44 platform that exists to reduce isolation and loneliness in
45 older people. The idea came about when I was helping out
46 an elder gentleman on my street, and he would fall out of
47 bed and I would go and pick him up and put him back into

1 bed. I also am on the Board of Medicare Victoria, so I can
2 see from the vantage point of the entire health care system
3 about how to save money, and I knew that my act of
4 neighbour-initiated care of putting this gentleman back to
5 bed was saving an ambulance trip, an ED presentation.
6

7 And when I started to talk to people about this, they
8 were saying, we do the same sorts of things, there's an
9 Italian Nonna that we look after, there's somebody else
10 that we look after. And so I saw this almost tapestry or
11 safety net of neighbours who are doing so much in the care
12 space and do so freely, and it adds value to them and adds
13 value to the community but it also adds value to the front
14 door of the Emergency Department.
15

16 So I designed One Good Street which was to develop a
17 participation culture within suburbs to make it really easy
18 for people to do great things for their neighbours, and we
19 link that to a map on our website which accredits those
20 streets, so streets change colour if you're a member of One
21 Good Street.
22

23 That idea and that innovation came from listening to
24 an auctioneer talk about the importance of social capital
25 and why you want to buy a house in this suburb, because
26 this is a thick market of social activity, there's lots of
27 social capital.
28

29 So I saw that we needed to reward streets for this
30 work. It's a channel, there's 730 members at the moment,
31 we are live in four suburbs. We run a range of
32 initiatives, but essentially if you're an older person and
33 need help you can reach out to that network and there are
34 plenty of people who will jump in.
35

36 We see people through the lens of neighbours, rather
37 than through NDIS, through other diagnostics or through
38 other funding sources.
39

40 Q. Can I take you back to ask you some more broad
41 questions about community resilience and connectedness.
42 So, in particular, from your perspective how does
43 loneliness impact on the mental health of individuals?

44 A. It can be a predecessor or come afterwards. It's
45 actually linked very much into chronic illness. So, when
46 you are experiencing a chronic illness of any description,
47 both physical and mental, loneliness and social isolation

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

8
9 One thing we notice, and I think this is key, is that
10 when we do initiatives or roll out initiatives to address
11 isolation and loneliness, people's health gets better,
12 people's mental health gets better.

13
14 There's an example in the submission by Judy Lowthian
15 at the Bolton Clarke Institute Research Institute, where
16 the project was to call older people over 75 years of age
17 once they were discharged from hospital and phone them
18 every week to check in on how they're going.
19 60-plus per cent reduction in depressive symptoms: the
20 answers are there.

21
22 Q. Just leaving One Good Street to one side, what is the
23 role for technology in reducing social isolation?

24 A. Technology definitely plays a role, but it is never
25 separated from the tactile. So, the digital and tactile
26 need to go hand-in-hand, so face-to-face services as well
27 as the latest technology, and we're lucky enough in
28 Melbourne we have a thriving start-up system, we have a
29 thriving social impact entrepreneurial system to draw from.
30 There is a huge design community as well that is intently
31 interested in doing work for meaning.

32
33 So, there's a group called Designing for Health with
34 140-plus designers who want to design in health care, and
35 so, at this point in time in Victoria, we've got this
36 confluence of activity that can deliver great technical
37 advantages, and homegrown solutions are there.

38
39 I'll just talk you through very quickly a few. One of
40 them is called Sofihub, which is artificial intelligence in
41 the home, and that's a voice that talks to you, it's about
42 the size of a drink bottle, and it reminds you to take your
43 medication, it reminds you the temperature of the day, and
44 older people who have this technology in their home, they
45 talk about it as being like a guardian angel presence
46 because someone's there talking and reminding them of
47 things.

1
2 There's another one called Umps Health, which is
3 really all developed here in Melbourne or Victoria, where
4 there is very, very non-invasive sensing in the house: so
5 plug, kettle, fridge, TV, microwave, and it builds up a
6 pattern of normal activity, and if there's a deviation from
7 that normal activity it sends an SMS to family, friends,
8 health care services to say, at 8 o'clock this normally
9 happens, this hasn't happened today. And that has real
10 benefit because, if you've fallen over in your house, then
11 you're only lying down for an hour before someone gets a
12 message, compared to 8 hours, compared to 12 hours. And
13 that's saving a lot of money for the health sector.

14
15 My Lumin is a brilliant easy tablet for older people
16 to have connections with their loved ones. And there's
17 something called Gabrielle Cares which is a beautiful
18 little robot that follows older people around in their
19 home. It detects falls, it can sense pain, it communicates
20 to others, and this technology doesn't require a tremendous
21 amount of upskilling of the older person, it happens
22 seamlessly.

23
24 So, technology can alert the rest of the community,
25 what I call a person's ecosystem, which is everything in
26 their life, that something may have changed. And we'll
27 talk later about CaT Pin which was developed here in
28 Melbourne as well.

29
30 Q. Those technological advances that you've described,
31 how do they then mesh with the tactile, which you've said
32 is also essential?

33 A. Absolutely. So, the technology in somebody's home or
34 what they are wearing should be alerting somebody to do
35 something, and there is machine learning and algorithms
36 behind that which is absolutely part of the solution. So,
37 it is a false dichotomy to think of it as all face-to-face
38 and no tech or somehow demonise tech. It is both
39 simultaneously improving their lives to help people not
40 just survive but thrive and flourish.

41
42 It is what that tech does with that information, that
43 data, and then who it reaches out to. For something like
44 One Good Street, it could reach out to One Good Street and
45 neighbours could go and check on somebody if they hadn't
46 been seen for a while or didn't turn up for an appointment,
47 so that's where that tactile comes in: it meets an

1 interface where humans then respond.

2

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

5 A. Yes.

6

7 Q. Can you just describe what that is?

8 A. So, CaT Pin is a wearable that detects loneliness.

9 I'd been visiting with community nurses, the Bolton Clarke
10 community nurses, and I had visited a woman who was 101,
11 and we were the only people who visited her that day, and
12 it was her birthday. And I left that house thinking about
13 the poverty of conversation of her experience at 101. And
14 then the very rich conversational life that I have, online
15 virtual, as well as face-to-face, and really there's such a
16 thin market of activity and there's such a thick market in
17 my life and a very thin one in hers.

18

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

35

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

43

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

1 The post person, newsagents, whoever, the community nurses,
2 care workers. Then that helps us to understand the
3 interventions and the people we should be intervening with.
4

5 It also helps target the interventions and isolation
6 of loneliness. So that, if Tuesday and Wednesday is the
7 day when most people who live alone with no-one in their
8 lives don't say anything to anyone, then what resilience do
9 we need to build in on Monday, what type of activities best
10 reduce people's burden of isolation and loneliness.
11

12 This is important because you're at 26 per cent
13 increased risk of mortality if you're chronically isolated
14 and lonely, and you also use services more. So, something
15 around 60 to 66 per cent increase in GP visits, in
16 Emergency Department presentations.
17

18 When I worked in Emergency, there was something we
19 called the positive suitcase sign. So, if an older person
20 turned up with their suitcase, we knew it was a social
21 admission. So, that gives you an idea of the impact of
22 loneliness in our tertiary healthcare system.
23

24 There are people that cannot be discharged from
25 hospital because there is no-one to discharge them to.
26 There's a home, but there's no food in that home, there's
27 no support in that home post their discharge. We want to
28 take what being discharged to the community could truly
29 mean with a different type of ecosystem surrounding that
30 individual.
31

32 Q. You've used the word "ecosystem" a few times and you
33 did explain it briefly earlier, but could really articulate
34 what you mean by that?

35 A. Absolutely. So, to give you an example, it is
36 everything in somebody's life, all the touch points in
37 their life. So, for many of us here today we may have
38 bought a coffee from some place, we may have had a
39 conversation, we may have gone to the newsagent before we
40 came here, they're all the - it's almost like the
41 choreography of your life and all the people you touch
42 along the way, all the resources and the systems and
43 services you interact with: that's somebody's ecosystem.
44 By respecting that ecosystem, that's where new technology
45 and startups can come in and then start to transform that
46 ecosystem, and potentially reorganise the resources that
47 are already there.

1
2 Because in our communities there are tremendous local
3 heroes doing great things, and a re-organisation of that
4 towards somebody who's isolated and lonely is incredibly
5 cost-effective, but it's also incredibly powerful for that
6 individual and for the community.
7

8 Q. You talked about before the potential uses for the CaT
9 Pin in terms of research and understanding of loneliness.
10 Has that progressed to that point yet, or is that sort of
11 in the ideas phase?

12 A. So, we have a prototype at the moment and we are
13 working with funders to build up a program of work, to turn
14 that into a prototype. We engaged with jewellery designers
15 so that we could design something that was very desirable
16 to wear and that's incredibly important in that co-design
17 piece with older people. Because many older people won't
18 wear technology if they see no benefit, but also when we
19 talk to older people they don't like the disability beige
20 that everything comes in. That's something Leah Heiss
21 always talks about, that disability beige.
22

23 We offer no purposeful design to make something that
24 is about disability into something that's desirable to
25 wear. So, we're at the early stages of it. Telstra Health
26 awarded us \$10,000 to start that work.
27

28 Q. Can I just ask for the "CaT Pin in Action" to be put
29 up? [WIT.0001.0056.0024] It's a bit difficult to read,
30 you might need to talk us through that?

31 A. Absolutely. We would like this to be socially
32 prescribed by a health professional.
33

34 Q. What do you mean by that?

35 A. So social prescription is when any clinician
36 prescribes to you an activity or an action based on agreed
37 goals. So, if you said to me that, "I would like to
38 exercise more because I've got blood pressure or for
39 managing my anxiety", then I would write you a prescription
40 to the local exercise club or the local walking club or the
41 local garden club, and then we would check in on that to
42 see how that's tracking for you and whether it was
43 achieving the goals of reducing your blood pressure,
44 helping you do more exercise, reducing your medication,
45 et cetera.
46

47 So there is a strong movement of social prescribing

1 across Australia and internationally but it's not
2 widespread. So, it would be important that these type of
3 things are prescribed based on assessment.
4

5 For example, for this lady here I would do a
6 loneliness assessment, social isolation assessment, which
7 is a validated tool, and then have a conversation with her
8 about this intervention. We would then set, if she decided
9 yes, I'd like to use it, we would set the parameters: how
10 many conversations would you like a day? And if she says,
11 I'd like to have about three or four, we would set that
12 into the software and then she would go about her normal
13 life. We would also explore what are the intrinsic things
14 she can do to have more contact with people and whether
15 that's assisting with ease of telephone communication or
16 scheduled phone book clubs or whatever it is that already
17 exists.
18

19 Q. And who does the prescribing?

20 A. We would like community nurses to be doing that and
21 especially GPs, because GPs have access to these
22 individuals. And that's what's important with this, is
23 respecting the ecosystem and the people that meet these
24 older people, and it is community nurses and care workers
25 that are in the homes of the most vulnerable in Australia
26 and that's our referral pathway, so we would be looking to
27 upskill them.
28

29 Then if the word count drops below that threshold
30 which we've negotiated and set, then an action happens.
31 So, instead of the internet of things, this is the internet
32 of actions. It then sends a message to family, friends,
33 volunteer phone service, it could send to neighbours, part
34 of the One Good Street network, and then we would respond
35 by increasing the word count through a conversation, so
36 it's conversation as therapy, or a home visit or an
37 activity.
38

39 Q. Could we talk through the diagram that you've got
40 here. Can you read that from where you are?

41 A. So, it looks like:
42

43 "Maria is alone in the family home. Her
44 husband Peter died seven years ago. Her
45 children are grown up and now live with
46 their own families.
47

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

5
6 "Maria's daughter Frances receives an alert
7 message."
8

9 Q. And that's just a text message?

10 A. Correct, just a text message. Then the daughter
11 phones her to lift the word count. Maria's phone rings,
12 she has that conversation. So, I think for the first time
13 we've got real-time intervention for loneliness and
14 isolation.
15

16 Q. Can I come back to ask you more about One Good Street.
17 You've described what its purpose is and why it was that it
18 was developed. Can you give some examples of what's
19 happening in the community who are members of One Good
20 Street?

21 A. We established the Library of Aged Care Things or the
22 Library of Care Things. It's Australia's first lending
23 library of aged care and care equipment. What was
24 happening on the Good Karma Networks, which are social
25 neighbourhood Facebook groups that have thousands and
26 thousands of people in neighbourhoods posting different
27 things, we saw postings of aged care equipment or care
28 equipment where people's loved ones either had gone into
29 care or had died.
30

31 What we did was we started to see all these posts and
32 we started to collect that equipment, because community
33 nurses, social workers, OTs and physios were reaching out
34 saying, we've got people who can't afford care equipment on
35 NDIS, on CHSP, on home package care funding.
36

37 So we started to collect that and then clean it, tag
38 and test it, and then give it away for free. So, we've
39 established a lending library of care equipment which is
40 free of charge to older people and it expressly has an aim
41 to support adult children who are looking after their
42 parents in their own home or in the parent's home.
43

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

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

8
9 Also the members knit cardigans, blankets, do a range
10 of things where we are producing things and giving them
11 away through all of our networks so that they reach older
12 people. We do Christmas hampers and we also do Ride To End
13 Loneliness which is a particular initiative from Cycling
14 Without Age, and that is giving older people who can't get
15 out of their homes any more because of inability or any
16 other reason, access to the community through a special
17 bike that they can sit in the front and we have trained
18 volunteers that take them out for a bike ride.

19
20 Q. And so, how do older people access One Good Street,
21 for example if it's on Facebook and they're not internet
22 users, how do they come to know that it's available or that
23 it's there?

24 A. The brilliant thing about it is, they don't have to
25 touch Facebook at all, the street itself becomes a better
26 place to live in for an older person. So, it's the
27 neighbours who are active on the Facebook groups are the
28 ones that start to reach out to those older people.

29
30 We also use our community nurses and care workers,
31 because we've got partnerships with aged care providers, to
32 let them know about all of those initiatives.

33
34 So, to give you an example, a secretary from a GP
35 practice posted saying, we need equipment because there is
36 a particular client who is very young and is palliative but
37 cannot afford the hire of a hi-lo bed, a wheelchair, a
38 commode and some other supplies. So, it was costing this
39 young person \$250 per week to rent this equipment and she
40 couldn't afford it.

41
42 So, the secretary from the GP practice posted saying,
43 "Please help", and within an hour that community had
44 responded and we had everything we needed. Within
45 24 hours, all of that equipment was delivered, so that
46 gives you an idea of the rapid response.

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

8
9 Q. Can I just ask, you gave an example earlier on about
10 an older gentleman in your street, and that you would go
11 and get him out of bed, and there is a system in place for
12 you to then inform family about that, and that's sort of
13 how this works?

14 A. Absolutely.

15
16 Q. Could you just explain what that system is?

17 A. So, whenever we access an older person, it's always
18 with their consent and also really respecting their
19 ecosystem, which includes their family members. So, often
20 it's the family members we're supporting initially because
21 it's the adult children that come in with that burden, the
22 carer stress of looking after dad but also managing family,
23 also managing career.

24
25 When they hear about One Good Street and that we've
26 got free equipment, and when they go and pick up the free
27 equipment and they have a conversation with someone that's
28 been through the same thing, they get benefit, so there's
29 always respecting that ecosystem and it's very
30 human-centred in that sense.

31
32 So there are pathways back, and because I work in the
33 health care sector I'm able to help people with those
34 pathways back and many of the members of One Good Street
35 are psychologists, OTs, physios, et cetera, in the
36 community. So, really there's this latent capacity within
37 the community. When we clock off from our normal clinical
38 jobs we're happy to share our expertise and our referral
39 pathways to make our suburbs better places to live.

40
41 I think the key is here, we're micro-ambitious, it's
42 just one street that I have to care for, it's not millions
43 and millions or thousands of people which is overwhelming,
44 because if we think like that then we've got to develop an
45 entire system as a response. This is street-by-street,
46 making streets better places and neighbourhoods better
47 places for older people to live, which is very achievable

1 when you break it down into those components.

2

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

15

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

23

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

27 A. Absolutely.

28

29 Q. As well as people who have experience like you in
30 nursing and other fields, it can be just members of the
31 public who choose to participate and help?

32 A. Absolutely, and what we do is, within the Facebook
33 group, is post content that is building capability. So,
34 we're telling stories about supporting people with dementia
35 in your community, supporting people who are dying in your
36 community, a range of initiatives.

37

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

47

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

12
13 Q. What has been the impact of One Good Street in terms
14 of, I think you talked about the estimate that \$30,000 of
15 care equipment had been reallocated to people free of
16 charge, what about how many members there are of the
17 Facebook group?

18 A. So, 730-something members on our Facebook group. We
19 recently have been giving out quilts and blankets to older
20 people via our partners but also as a way of encouraging
21 neighbours to go up and interact with their older
22 neighbours.

23
24 We also have been running a range of initiatives that
25 help lift the profile of the role of older people in our
26 community activities. Our partnerships are really
27 important and that's with people like the Good Karma
28 Network, with Bolton Clarke, with Kensington/Flemington
29 Rotary, and there is this porousness where they will say,
30 hey, we need something; we say we can do that, or hey, you
31 need something, we can do that.

32
33 We also post a lot of opportunities from other
34 organisations because we don't want to produce a whole lot
35 of stuff, we want to support what the ecosystem is already
36 doing and running it through our platform which gives our
37 volunteers frequency and variety. The work done in Lambeth
38 and Frome in the UK really showed that you can transform
39 suburbs if you make the volunteering experience amazing.

40
41 Q. Can you just talk a bit more about that?

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

1 community, and in Australia we do it in a flood, in a fire,
2 the Australian spirit comes out and we help each other out.
3

4 This type of initiative is making that tangible and
5 breaking up into small activities weekly and daily for
6 people to actually contribute to their society.
7

8 So in Lambeth, they rolled an amazing program out
9 called Designed to Scale. It was all about developing a
10 participation network within suburbs and activating the
11 suburb. They did a range of initiatives including communal
12 orchards, tool sheds, a whole range of things that changed
13 the character of the suburb.
14

15 In Frome, they did social prescribing to local
16 initiatives, to garden clubs, to aged care activities, to a
17 whole range of things, and they had a 14 per cent reduction
18 in Emergency Department presentations for people over 75
19 with comorbidity suffering from social isolation.
20

21 So, if we can enact our neighbourhoods, enliven them
22 with a whole range of social impact initiatives, we will
23 see a change at the Emergency Department front door,
24 because people are being looked after better in the
25 community, especially those most vulnerable.
26

27 Q. What are some of the challenges that are being faced
28 in implementing One Good Street?

29 A. The funding mechanisms are often financial year, but
30 we're dealing with people's lifetimes, and sometimes there
31 is an organic nature to what we do in the community that
32 requires time for it to evolve, and also a risk tolerance
33 that is different when you are doing things in the
34 community.
35

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

1 community, so there's that.

2

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

14

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

28

29 Q. Based on your experiences with One Good Street, what
30 are your reflections on the strengths of such a model?

31 A. The cost of One Good Street is a fraction of what is
32 being funded currently, so it's a very achievable model.

33

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

47

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

14
15 Q. In terms of what you've described, there's clearly
16 potential for broader applicability in other communities?

17 A. Absolutely. People have reached out to start One Good
18 Street or One Good Town across Australia, and often they're
19 concerned because they are either rural or
20 non-metropolitan, that they won't have the resources, and
21 what I find is, when I talk to them, that they actually do
22 have a range of neighbourhood Facebook groups, that they
23 could either join together or introduce another one that
24 covers that with a real focus on isolation and loneliness
25 in older people, supporting older people, and that there
26 are all of those antecedents there within the
27 neighbourhood.

28
29 Certainly looking at Lions, Rotary, Probus, all of
30 those forgotten heroes in Australia who constantly do
31 amazing things and are looking for renewal, is bringing
32 them into this new way of doing things, and then that
33 partnership with schools and tertiary education, and also
34 looking at volunteerism, where individuals are shared. So,
35 if you're a volunteer, you actually can be shared between a
36 range of organisations which then gives you more variety
37 and frequency, so you would volunteer more because it's
38 incredibly exciting.

39
40 The other sorts of things that we need to see for this
41 to scale up - but I also acknowledge that scale up may not
42 be achievable, that there may be organic things that happen
43 in communities that will struggle elsewhere, and that there
44 will be place-based differences. I think that's an
45 important thing, because we can't have assumption that one
46 model that works here can be scaled up everywhere. There
47 may be elements of it that may work, and I look to Men's

1 Shed on how they've scaled up, the Men's Sheds and the
2 She Sheds across Australia; it gives us an idea. And when
3 talking with them about the - that some thrive and some
4 just survive and teasing out what are the elements of that,
5 they're all things to be taken into consideration.
6

7 But there may be organisations and parts of the
8 society that don't need it because they've already got
9 established networks in place, and that's that real respect
10 for the ecosystem, respect for the goodwill that's already
11 out there in the community.
12

13 Q. Are there any early lessons or other factors that
14 should be taken into account when considering replicating
15 similar models in other communities, aside from what you've
16 said about scalability?

17 A. I think it is important, yes - I think we need to
18 evolve our sense of co-design, and co-design is just an
19 initial phase, but co-leadership and co-production takes
20 that citizen science even further.
21

22 There is a body of evidence around citizen science
23 that looks at citizens conducting their own rapid
24 prototyping, their own hybrid citizen experiments to
25 deliver value to the community and supporting them to do
26 that, that it is very much crowd-sourced. So, there are
27 lessons in allowing that to happen, create space for that,
28 allowing the organicness to happen.
29

30 But also to introduce new things, because communities
31 don't know an exhaustive amount of possibilities for them.
32 So, yes, importing and then changing and massaging other
33 initiatives that have worked well, and I think that's the
34 duality.
35

36 And having a tolerance for failure and a tolerance for
37 things not to work, then we can rapidly prototype, acquire
38 on Tuesdays and then work out that it doesn't work, and we
39 need to do it on a Saturday, and we need to link it to tea
40 and coffee and it needs to be linked to the gardening club.
41 That's the type of environment where innovation can
42 flourish and also local creativity can flourish. So,
43 there's work to be done on creating environments that are
44 very, very permissive, we can manage the risk, but allow
45 that creativity from the community and from outside to kind
46 of collide.
47

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

3
4 COMMISSIONER McSHERRY: Q. Thanks very much for your
5 testimony, and I admire your passion at trying to connect
6 team. I'm just wondering whether there might be some
7 challenges, though. We've seen recently that certain
8 organisations - I'm thinking about the Cambridge Analytica
9 scandal and so on - is there perhaps a challenge with
10 technology coming into the home, that the data that's
11 gathered might be accessible by others? That's the first
12 question.

13
14 The second question is, when you're monitoring people
15 for social isolation, is there a challenge that other
16 people will think, oh, someone's going to come to help: if
17 someone doesn't, well, who has a duty of care, I suppose.
18 As you said, it's very much based on a participation
19 culture, but what happens if people don't participate?
20 A. Absolutely. So, the producers of the technology are
21 very cognisant of that. So, the challenge for them is to
22 ensure that that data security is well in place, and that's
23 incumbent on the developers of that, and also the aged care
24 providers that are utilising that for their own safeguards
25 to ensure that it's a very, very closed system; that, if
26 you've got sensors in your home that are letting me know
27 whether you are - and you've consented to it - that the
28 data is stored securely and that the messaging that goes to
29 the community nurses to say you haven't gotten out of bed -
30 because it exists within a model of care - and though the
31 frameworks and safety guards around the model of care
32 should be protecting. But that's an evolving conversation.

33
34 To confirm that, on Facebook no addresses' identity is
35 ever revealed, so that was all done behind the scenes,
36 nothing is ever put out into Facebook around this person,
37 naming them, needs help; that's all done behind the scenes
38 to protect people's privacy, their autonomy, and that's
39 incredibly, incredibly important.

40
41 The one thing I would say about - because often the
42 conversation is around, what's the risk for elder abuse?
43 The more people you have in your life from diverse
44 perspectives the less you're able to experience elder abuse
45 because you're having a whole range of people check up on
46 you. So it is protective to have a range of people in your
47 life. But we can control for that, to ensure that what

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

5
6 The second one was about the duty of care. So, the
7 partnerships arrangements with One Good Street and care
8 providers like Bolton Clarke and community houses, that's
9 where that added layer of protection is.

10
11 When community nurses visit older people and no-one
12 answers the door, they often will talk to neighbours, or
13 the neighbours will come out and see the car and say, hey,
14 I haven't seen this individual, I think they're in
15 hospital. So, the neighbourhood is a source of
16 information.

17
18 By providing them with a legitimate place at the table
19 as part of the care team, we can then build capability and
20 control for risk, but also, we get more data points about
21 that individual and it's a safety net for them.

22
23 What we would do, for example with the CaT Pin, is to
24 have a range of SMS alerts, and you can build the
25 technology so that it sends an SMS to you, because your
26 grandmother hasn't spoken all day, and then if you don't
27 respond it has a secondary and potentially a third contact,
28 so you've got that process in place.

29
30 If it's been prescribed by a GP or a community nurse,
31 then we know that we've got community nurses and care
32 workers going in daily, because this is really targeted for
33 those individuals that are receiving services already, or
34 are on the at risk registry because they're 85, live
35 totally alone with no family in West Melbourne, for
36 example. That's the type of person who already exists
37 within a framework of duty of care because they're
38 receiving a range of services through Package Care, for
39 example.

40
41 Q. Could I just ask, as a quick follow-up, which of the
42 four suburbs are involved?

43 A. So, North Melbourne, Kensington, Flemington and West
44 Melbourne.

45
46 Q. And you're thinking of rolling this out across
47 Melbourne and perhaps country areas? You mentioned --

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

4
5 COMMISSIONER FELLS: Q. I imagine you've come across the
6 Putnam, Bowling Alone, and all of that which some of us got
7 our education from, and I think it was called something
8 like, "The collapse of American community", but also some
9 revival. So, how do you see all that literature which
10 tells us that the community is collapsing, but what's your
11 take on that in the light of all the excellent things that
12 you seem to be doing?

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

22
23 And also, with the possibility of rewarding and
24 accrediting and social credits for example, it offers new
25 opportunity to reward people that is not monetary.

26
27 One thing I would say is that there's no - I'm not
28 ready to put the curtain down on community activism as yet.
29 So, we've got incredible energy around environmentalism,
30 about making our homes more sustainable and making our
31 suburbs and cities more sustainable, and that's what we're
32 hearing about constantly. And that for me, I'm stretching
33 that to include older people, isolation and loneliness.

34
35 So, I haven't discovered apathy in the community on
36 this. What I've discovered is that there is a pool of
37 people that want to redeem the ageing experience of their
38 parents and they have put their hands up to say, I want to
39 help older people, because they weren't satisfied with how
40 their mum and dad were treated in aged care, so they're
41 highly motivated to get involved.

42
43 What I think can assist is coupling One Good Street
44 and this movement to help older people thrive in our
45 society and respect them more is the fight against ageism,
46 which is incredibly important; to look after CALD
47 communities and LGBTI seniors as well, and couple that with

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

5
6 CHAIR: Q. I have one last point to ask you about in
7 terms of the reflections about that. We've heard a lot
8 through this Royal Commission about the stigma around
9 mental health and mental illness, and thinking about
10 whether you have experience or how you think the model
11 applies for those community members who might be older but
12 also have mental health issues and what role something like
13 your One Good Street could have.

14 A. I think, the key would be to focus that individual as
15 the neighbour who needs assistance, and if we view them
16 through the lens of that neighbour: this is just someone in
17 my neighbourhood who may have a range of things in their
18 lives, but they are a neighbour, so they're an enduring
19 presence in my street.

20
21 So, I can be informed via providing content through
22 the Facebook group about anxiety, about depression, about
23 suicide risk in older people. There's ways we can inform
24 the community, what we call at the Health Transformation
25 Lab, guerilla information provision, where you are
26 messaging the community on a regular basis in ways they're
27 not expecting to hear about: the suicide rates of older
28 people, you can do that through a range of social media
29 channels; people with mental health issues who often are
30 well engaged on social media when they've got digital
31 connectedness, so there's ways to provide
32 capability-building within the suburb.

33
34 The referral pathways are really useful so that - and
35 this happens now, so Ozanam House will call me and say,
36 we've got somebody who needs XYZ, can you help, and I push
37 that out saying, this is what I need. Or I've got a range
38 of people that can already jump in.

39
40 So it is those referral pathways and the timeliness of
41 it, the ability to do it in a day. Some of the
42 organisations can't believe that they've phoned in the
43 morning and then, on the way home from work, one of the
44 volunteers already drops off the equipment. That's unheard
45 of. They expect a wait, they're actually shocked, oh my
46 God, here it is, you've had a response? But that's how the
47 community can respond.

1
2 So, those trusted partnerships, those referral
3 pathways in and out, building capability, because people
4 within our neighbourhoods experience a whole range of
5 mental health fluctuations in the phenomena of their life,
6 and there is this capacity to assist, to guide, to support,
7 all through the lens of this is just a neighbour who needs
8 help. It really normalises that as part of the tapestry of
9 our neighbourhoods.

10
11 CHAIR: Thank you very much.

12
13 MS COGHLAN: Thank you, Chair. May Mr Bush please be
14 excused?

15
16 CHAIR: Yes, thank you very much for your exciting
17 developments and thank you for coming and giving your
18 evidence today.

19
20 <THE WITNESS WITHDREW

21
22 MS COGHLAN: Is now a convenient time to break for lunch?
23 I understand we'll be returning at 1.45.

24
25 CHAIR: Thank you

26
27 **LUNCHEON ADJOURNMENT**

28
29 **UPON RESUMING AFTER LUNCH**

30
31 MS COGHLAN: The next witness to be called is Jane
32 Anderson, and I call her now.

33
34 <JANE ELIZABETH ANDERSON, affirmed and examined: [1.50pm]

35
36 MS COGHLAN: Q. Ms Anderson, you've provided a statement
37 to the Royal Commission?

38 A. Yes, I did.

39
40 Q. I tender that statement. [WIT.0001.0058.0001] Can you
41 please detail for the Commissioners your background and
42 experience?

43 A. Most previously to the current role of the Latrobe
44 Health Advocate, I was the Regional Director of Anglicare
45 Victoria in Gippsland. Before that, I was a lawyer in
46 community practice and also private practice and, before
47 that, I was a member of Victoria Police for 11 years.

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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

1 and the Latrobe Health Assembly. Can you just elaborate on
2 those aspects?

3 A. Yes, so Latrobe City was designated as the Health
4 Innovation Zone, which in essence means it's the area that
5 is dedicated to improving health and wellbeing and
6 innovating, doing things differently in doing that.

7
8 The Latrobe Health Assembly is a unique structure in
9 its set up, in that it's a legal institution that brings
10 together the CEOs from the hospital, the community health
11 service, local government and the Primary Health Network,
12 and also representation from the Department of Health and
13 Human Services with community members on the board, and
14 then also the assembly itself has community members.

15
16 It's unique in the fact that it is legal, bringing
17 those people together and working with the community to
18 ensure community-led decision-making and community-led
19 improvements for the health and wellbeing in Latrobe.

20
21 Q. So, how does the role of the Latrobe Health Advocate
22 contribute to the zone?

23 A. So, my role, as I said, is independent but works in
24 collaboration with particularly the Health Assembly and
25 with the other organisations within the Health Innovation
26 Zone. A key part of my role in hearing the voice of the
27 community is to engage the community and hear from them in
28 a way that they may not have had their voice previously.

29
30 So, I particularly focus on people who either don't
31 recognise their voice or don't have the opportunity to
32 provide their voice, and I've engaged with the community in
33 different ways: in going to the community where the
34 community is, acknowledging that they're living in
35 different contexts and they're in different places.

36
37 So, I've done things like catch the buses and talk to
38 people on the buses and at bus stops. I go to community
39 events and I ask open questions from the community around
40 what are their priorities for improving health and
41 wellbeing and what are their suggestions for improving
42 health and wellbeing.

43
44 So a key part of my role is hearing those voices from
45 the community in different ways so they can have their
46 voice, and then I take that voice through to other
47 decision-makers, whether or not it's government or whether

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

6
7 Q. You've talked about taking the things that you hear to
8 the Assembly. Can I just ask more specifically how your
9 role as the Health Advocate works with the assembly?

10 A. Yes, independent of the assembly but working closely
11 and collaborating with the assembly. So, I will attend
12 Assembly meetings at different times and I will attend the
13 board meeting of the Assembly, but then I also interact
14 with the Assembly members individually and separate from
15 that as well.

16
17 Q. One of the things you mention in your statement is
18 that having community members and the leaders of the major
19 health services in the room together creates a space where
20 the status quo can be challenged?

21 A. That's right. It is unique that they are coming
22 together in that legal structure, and so, it is an
23 opportunity to bring what I'm hearing from the community
24 through to those people as a group, and so, the opportunity
25 to actually influence the way that they're doing things is
26 greater.

27
28 Q. Can you talk about some of the strengths of this model
29 that you've described?

30 A. So, what's particularly strong in my view of the work
31 within the Latrobe Health Innovation Zone is that it is
32 localised and it is looking at the place and the context in
33 which people live their lives.

34
35 We're aware in Latrobe that there are health
36 challenges, and those challenges have been there for quite
37 some time. So, by having a Health Innovation Zone we're
38 doing things differently to improve the health, because
39 health hasn't been improving there recently, so we do need
40 to change the trajectory of some of the issues.

41
42 One of the strengths is being aware of the context in
43 which people live, having the community-led
44 decision-making, and also people having a shared focus
45 around what the issues are in Latrobe. So it is the
46 opportunity to really highlight the importance of health
47 and wellbeing. While we've got economic development we're

1 bringing health and wellbeing as a priority together which,
2 when we join them, we've got the greatest opportunity for a
3 prosperous community.
4

5 Q. One of the strengths you identify in your statement,
6 just picking up on what you've said, is about these
7 place-based approaches and methods that can empower
8 communities and individuals in that context. Can you
9 expand on that?

10 A. Yes. So, having community leadership in relation to
11 different initiatives, having their strength at something
12 like the Latrobe Health Assembly, it gives the opportunity
13 for them to inform the things that need to occur.
14

15 One of the examples is the Hello Campaign. So, people
16 identified in Latrobe that there needed to be greater
17 social inclusion, greater connection between people. So,
18 Lifeline Gippsland were able to look at what could be done
19 in that space and they were able to bring the community
20 together with the Health Assembly and also then with the
21 government to see what could be done differently.
22

23 The Hello Campaign was one of those initiatives that
24 came from the community informing directly the services and
25 what could be done. It started from a suicide prevention
26 aspect and as a precursor to having a "Are you okay?"
27 conversation and actually establishing a relationship with
28 someone before you could say: "Are you okay?".
29

30 Q. Do you have any idea about how that's gone in
31 practice?

32 A. Yes, I've had feedback recently when I've caught the
33 buses this week and I've talked to people, and the Hello
34 Campaign was initiated just a couple of months ago, so when
35 I caught the bus this week people actually talked to me in
36 the street about the value of that campaign.
37

38 With that campaign people are actually handing out
39 "Hello" cards. So, they are seeing someone in the street
40 and they are saying "Hello" when they are handing out these
41 cards which assists people in how they can say "Hello" to
42 others, and they're doing it in cafés and sporting grounds
43 and different locations, and people in the community are
44 actually talking about saying "Hello" to more people.
45

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

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

6
7 Q. Can I ask you about those learnings or those early
8 lessons, and your view really on factors that should be
9 taken into account when considering replicating or
10 expanding similar kinds of models in other communities?

11 A. I think it's really important that there is time spent
12 on developing the relationships in which people are
13 working. I think often we talk about partnerships but
14 actually for the model to work we need true collaboration
15 and that means that people are actually compromising and
16 that takes a trusted relationship to compromise and to come
17 to true collaboration, so we need to invest in the time.

18
19 We also need to be very conscious of the power
20 imbalances and having good communication. There's no doubt
21 that people from the health sector, like other sectors,
22 have a language and people in the community don't
23 necessarily understand that language. So, it's important
24 that unequal power issues are identified and addressed and
25 people are aware of the position that they stand in, so
26 people can come to things equally.

27
28 It's also important that we build on the existing
29 strengths within the community. So, whilst we have a
30 Health Innovation Zone and we need to change things, it's
31 not everything that needs to change. So, it's important
32 where there are small organisations like neighbourhood
33 houses who have been trying to innovate and doing things
34 differently and are innovating, that they're actually taken
35 on the journey and they're not excluded or ostracised from
36 the processes, so the strengths in the community are built
37 upon.

38
39 I think it's also important that, whilst things are
40 focusing on health and wellbeing, there's lots of different
41 activity that occurs in the community, whether or not it's
42 from local government, state government or organisations
43 that are focused on health and wellbeing, and if we're not
44 careful to align the energies and the action then we can
45 have lots of things going off in different directions. So
46 it's important to align the work and have a common agenda.

1 I think that engagement with the community is also
2 important. When I commenced in the role people talked
3 about consultation fatigue and that people in the community
4 were tired of talking to others, and what I actually found
5 is that, when I was going out into the community going to
6 places where they were and asking open questions and
7 listening to what they had to say, that there was no
8 fatigue from the community; they absolutely wanted to
9 contribute to change, but I think it's about how others are
10 supported to engage meaningfully with people and actually
11 hear what people have to say and want to say.
12

13 I think there's probably another area that is a
14 learning which is also around how local context operate in
15 a statewide and a national arena as well. So, when there
16 is statewide policies and they are being sought to be
17 changed and give value to what the community is looking
18 for, how those statewide policies can be adapted to the
19 local area.
20

21 The last area that I'd say is a learning is around
22 risk. It's difficult for governments and departments to
23 take risk, and it's challenging for the community to allow
24 others to take risk and allow for failure as well. So, I
25 think we need to have the right environment that allows for
26 those risks to be taken.
27

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

30
31 "The role of governments and services needs
32 to continually evolve."
33

34 A. That's right. I think things can be done at one
35 point in time but one of the things I would say about
36 innovation is that it is a continual learning and a
37 continual development, so people need to be - when I say
38 people, organisations, all the various stakeholders - need
39 to be able to adapt to things as they go along.
40

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

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

1 90s, where that was a safety net for people having work,
2 and for families that was often the career trajectory that
3 they looked for their family, where they would be safe and
4 they would have secure jobs.

5
6 So, from the privatisation, that impacted the
7 community significantly. Then we've had large impact
8 disasters. From the 2009 fires through to the 2014 mine
9 fire and then also now the closure of coal-power stations.
10 So, it's quite a complex community. There's generational
11 issues. It's how the community can be supported to
12 transition into a new future, because it certainly is a
13 transitioning community and people are looking for what is
14 meaningful for them into the future and what can they look
15 for.

16
17 Just this week - again when I was talking on the buses
18 - people were saying they're looking for motivation: so,
19 what's the motivation that is in Latrobe for individuals to
20 actually change things and transition to the future?

21
22 Q. One of the things you talk about in your statement is
23 the conversations with people living in Latrobe, expanding
24 on perhaps the conversation on the buses, that mental
25 health and wellbeing is the most common issue raised?

26 A. It has been the number one issue that people have
27 raised with me in the last 12 months. So whether it is on
28 the buses or at community events or people coming to talk
29 to me, they have talked about their concerns for mental
30 health of themselves or particularly for those in the
31 community. It's been quite caring, the conversations,
32 being concerned about others.

33
34 They've talked about often the connection between
35 mental health and other issues, whether it's family
36 violence, alcohol and drug, whether it's stressors in
37 day-to-day life. They've also talked about their concerns
38 for the person down the street. There's an example that
39 comes to my mind when I was talking to people at the Men's
40 Shed, and they said that, "We know that there's a fellow
41 down the street who's by himself, but when we knock on the
42 door he doesn't want to engage in conversation, but we know
43 he's not coming out." So they've got concerns around
44 people being connected to other things in the community and
45 particularly social inclusion and loneliness.

46
47 Q. One of the ways that you are informed about the health

1 and wellbeing is through the Hazelwood Health Study. Can
2 you just talk about that in relation to particularly
3 students, young people?

4 A. Yes. So, it was a recommendation from the Hazelwood
5 Mine Fire Inquiry to actually have a long-term health
6 study, and the health study has looked at the psychological
7 impacts of the mine fire. They have identified the stress
8 that people have felt from the mine fire, but also the
9 stressors that children in schools felt.

10
11 Sometimes those stressors were impacted by their
12 parents, and so, children have suggested that there are
13 things in schools to support them to deal with those
14 stressors when they may not be sleeping at night or it's
15 impacting their studies, and also that there be
16 communication with them so they can be aware of the
17 situation and they're not necessarily relying purely on
18 their parents whilst information from their parents is very
19 important, but they wanted to see from other areas as well.

20
21 Q. You touched on this before, but you talk about that
22 through your engagement with people in Latrobe you've had
23 the privilege of hearing many ideas and aspirations for a
24 prosperous and healthy future.

25 A. Yes, people have been, as I say, keen to have their
26 say and they are very conscious of wanting to change things
27 so it is better and they want to contribute to what it is
28 that is better in the future.

29
30 Some of the suggestions that they have had around
31 their ideas and things that work, have particularly around
32 events where people do come together. I've attended some
33 of those events and what I've found, is that the consistent
34 thing is that there's a shared interest and then also a
35 social activity.

36
37 So, I went to a group that's the Yinnar Wellness Group
38 and they are a group of people aged from 60 to 98, and they
39 actually talk about the pieces of metal in their body. So,
40 they're not very active, and what they find is that coming
41 together in this activity once a week, so it's called the
42 Yinnar Wellness Program, they are coming out, they connect
43 with others that have shared experiences and they have an
44 exercise therapist who takes them through very gentle
45 exercise, and that is having significant benefits for them.

46
47 They even talked about one person there who wasn't

1 going to be released from hospital until the hospital saw
2 the exercises and the program that they were going to do
3 here, so it actually allowed them to be released earlier
4 from hospital to come back into their community and connect
5 with others.
6

7 There's a range of different activities that are
8 occurring in Latrobe that do bring that shared focus and
9 social activity. Another one that has had great impact is
10 Streetgames and when I've gone and visited Streetgames I've
11 gone to areas where I know people are experiencing really
12 difficult times. There's often experiences with child
13 protection involvement in their families, issues in
14 relation to financial stress, family violence issues, and
15 I've seen those families at the Streetgames events, where
16 the kids have got engaged in the activities, again because
17 it's accessible to them, they see that it's happening, they
18 see it publicised and they just see people gathering.
19

20 I've been at one of the local schools where there was
21 over 80 people at one of the Streetgames events. What also
22 happened is, from the kids coming together and connecting,
23 the parents were then actually connecting as well, and the
24 parents were then saying, "We want to do other activities."
25 They said, "We want to play tennis", and so, then
26 Streetgames provided activities for the parents. It's that
27 sort of activity where people can come together in the
28 community.
29

30 It's similar through other activities like Parkrun,
31 Heart Foundation walks where I've been on walks with
32 people, and again, it's people that - one person told me
33 her story where she was recently widowed and she didn't
34 know what to do, she didn't know where her friends were,
35 and someone suggested this walk to her, so she came on the
36 walk and connected with other people as well. So, those
37 sorts of initiatives and ideas have really benefitted
38 people in the community, and that's the sort of thing they
39 say is important for them.
40

41 Q. You talk in your statement about your engagement with
42 local Aboriginal communities.

43 A. I've heard from the Aboriginal community the work that
44 they're doing, there's particular places like The Gathering
45 Place where people are coming together where they feel that
46 it's a safe place for them to come.
47

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

9
10 I'm seeing a really strengthening connection within
11 the Aboriginal community and people, again, wanting to come
12 together and share their experiences with each other and
13 celebrate where they can celebrate.

14
15 Q. You refer in your statement - and I'll just read this
16 part to you:

17
18 "Experiences in Latrobe have shown that,
19 for some, resilience can be strengthened
20 through adversity."

21
22 Can you just expand on that?

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

29
30 So, what I've seen through working and living in
31 Latrobe - and I experienced the impacts of the mine fire
32 along with many other people - I saw the community voice
33 getting stronger and stronger, and I haven't seen it as
34 strong as what it is now.

35
36 So, what I've seen is that through that adversity of
37 the mine fire, in some ways it's been a catalyst for
38 change, but it's also been a catalyst and a call for the
39 community to strengthen what they need and for them to take
40 on responsibility to say, we want others to respond to what
41 we're needing.

42
43 Q. I want to ask you about what it takes to support and
44 improve community resilience. Can you address that,
45 firstly, at a government level?

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

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

3
4 What I've found is places like neighbourhood houses,
5 Men's Shed, local community groups, they have a real part
6 to play in supporting people's improvement in mental
7 health, and I think there's space for them to be
8 acknowledged more in funding models and policies.

9
10 I also think there's space to look at more sustainable
11 volunteer models. So, where I've been to community
12 gardens, I see volunteers there who do an amazing job, but
13 often what they need is something, whether or not it's a
14 partnership with another organisation or it's a bit more
15 funding, to just give them that backbone from a
16 funding/administrative perspective, to be able to sustain
17 the work that they're doing.

18
19 Q. Moving on then to the mental health and broader health
20 education and social services sector.

21 A. I think the things that the sector and other services
22 can do is particularly consider the approach from services
23 and how they can change their approach: to be approachable,
24 to be accessible and to show empathy.

25
26 There's one person who I talked with on the bus
27 six months ago when I was on the buses - and I'm talking
28 about the buses because I've been there this week so it's
29 fresh in my mind about people's experiences - and I talked
30 with her again on the bus this week, and she said
31 six months ago there was nothing for the age group of 18-22
32 to do. She said there are things for younger people,
33 things for older people, but there wasn't anything for her
34 to do.

35
36 What she said to me this week is actually, there's now
37 a youth space where she feels as though she's able to go to
38 that space, and it's something where she can be comfortable
39 and she can sit on the phone and access the WiFi if she
40 wants to or she can talk with people if she wants to, but
41 it's just a welcoming place.

42
43 She also talked about mental health services that
44 she's accessing and that too had improved. They're now in
45 her local town, so she doesn't have to get public transport
46 to another town. She said, in the environment that she's
47 seeing them, it's in a community setting. She said they've

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

3
4 Also, there's knitting, so if she wants to she can sit
5 and knit or she can sit on the couch and again she can talk
6 to the services if she wants to.

7
8 I think there's particularly something in that space
9 around approachability and accessibility for services.

10
11 Q. What about in the community?

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

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

24
25 The other thing about community, the thing that they
26 can do, and they are doing, is bringing people together - I
27 think this is where we can see more of that. I've seen in
28 a local community centre in Traralgon East where again they
29 heard from people in the community what they wanted to do,
30 and the community said, well, we need activities for
31 children, we need activities for families. We also need to
32 access food, because we don't have a lot of food, and they
33 also talked about clothing, and so, at this community
34 centre now there's pop-up op shops. So, the op shop just
35 comes in and people can get clothing, they engage in
36 children's groups.

37
38 There was someone who I spoke to at that community
39 centre where she actually said, that morning she was
40 feeling the weight on her shoulders in her home, she's got
41 chronic illness, and she wasn't sure about going out the
42 door. But she knew that there was a lunch at the community
43 centre that day, so she actually walked out the door, and
44 then she said, when she got to the street, she walked up
45 the street and she felt better for going for the walk up
46 the street. Then when she actually got to the centre, she
47 actually described the weight coming off her shoulders and

1 how good she actually felt being there. So I think it's
2 those sorts of things that the community can do and wants
3 to do, if properly supported, to bring people together.
4

5 Q. How does disadvantage, education, and employment
6 impact mental health from the Latrobe experience?

7 A. What people have talked about or what I'm aware of
8 particularly is issues of generational disadvantage. So,
9 where we have seen from the impacts of different events
10 over the years, where kids are born in an environment where
11 there may be family violence in the home, or there's
12 financial stress, and their parents haven't been able to
13 get work, and so, kids are born not knowing the skills and
14 how to deal with different challenges. So, what can help
15 them to break that cycle, so I do see issues of
16 generational disadvantage.
17

18 Those families then, the support that they need to
19 actually be the best parents they can when they have kids.
20 So, I can see that in different areas. But what I hear
21 from people is, their desire to have that purpose in their
22 life. So, whether or not it is volunteering or whether
23 it's about sharing an interesting, or whether it's about
24 seeking a job, and they do want to have more skills.
25

26 I've heard from people around the value of free TAFE,
27 what that meant for them, that they actually did want to
28 educate themselves but it just wasn't something that they
29 were able to do. So, having the accessibility to education
30 and then how that is able to support them into employment
31 has been valuable.
32

33 But then, the employment challenge in itself has
34 impacted their mental health. So, they've talked about the
35 effect of applying for jobs and getting knock-backs and how
36 that affects how they're feeling.
37

38 I've heard comments from people from a different
39 cultural background of the challenge of getting their
40 skills recognised, and someone actually told me that they
41 applied for a job and they were a qualified person. And,
42 when they sought feedback because they didn't get the job,
43 the response was that they should change their name.
44

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

1 pushing against them, are very challenging.

2
3 Q. Can I ask you about perhaps a broader area, which is
4 that: you say in your statement there are some areas, and
5 the Latrobe Valley is one of them, for which there is a
6 stigma about the location?

7 A. Yes, I think as a result of particular events and in
8 particular when it can be sensationalised by the media and
9 perceptions that people have of the area, then that impacts
10 how people feel about themselves, it impacts how they feel
11 about feeling proud of that area.

12
13 There's a campaign at the moment, which again is an
14 initiated through the Health Innovation Zone, called "We
15 Are Latrobe", and it's about drawing out people's stories
16 about why they are glad to live there and why they are
17 proud of living there. Because we do know that the stigma
18 affects how people feel.

19
20 Again, I heard that on the buses when people were
21 talking about motivation, how do they define motivation?
22 What is their future? So, it's great to see the positive
23 campaign where those sorts of issues can be addressed in a
24 positive way using the stories of people in Latrobe to
25 reduce the impact of an outside view of people in Latrobe.

26
27 Q. Looking to the future, what can be done to prevent
28 mental ill-health and better meet the mental health needs
29 of the community?

30 A. I think there's a range of things that need to be
31 done, but what I would say in particular is taking a view
32 of health services, a broader view of health services, so
33 looking at a social model and holistic view, so people's
34 lives are taken into account when health services are
35 providing a response.

36
37 I talked to someone - and this relates to employment
38 and getting financial support - but she was talking about
39 getting services from Centrelink, and she was being
40 required to go and apply for jobs. She was six months
41 pregnant. She disclosed to me that she had lost a baby in
42 the year before, so she was actually very protective of her
43 pregnancy, and so, she didn't feel comfortable going out
44 and seeking employment when she was six months pregnant.
45 She also said, "Who's going to employ me when I'm going to
46 have a baby in three months' time?" So I think it's those
47 sorts of things, taking awareness of the context in which

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

3
4 I think there's also a role in reducing the stigma,
5 particularly in regional areas. There's a part that health
6 services can play in reducing stigma because they are a
7 part of the community and they are a large employer. So,
8 the roles that people in health services in their own
9 community in reducing stigma can impact others, so I think
10 there's a real role there in the prevention space.

11
12 The other area around prevention is addressing the
13 issue of social isolation and being concerned about people
14 where they don't come out, or you can't get in through the
15 door. People have talked about - there's a model that's
16 being explored in Latrobe at the moment around social
17 prescribing, so linking people into different activities
18 that links that shared interest and a physical activity and
19 social aspect together.

20
21 I think there's another thing around the design and
22 location of services. So, there are models internationally
23 where emergency departments are redesigned so people
24 actually - it's not that traumatic impact of going in
25 there, it's almost an enjoyable thing, if you can say it in
26 that way, to go into the health service door.

27
28 People even talk to me about the Royal Children's
29 Hospital here, how it is a great experience for people to
30 go to, so I think there is something about the design of
31 services so they are in their location and their
32 accessibility is not daunting for people.

33
34 Q. What significant social changes are likely to affect
35 reform efforts aimed at better preventing and responding to
36 mental health challenges?

37 A. I think some of those things are in relation to,
38 particularly in Latrobe's example, the transition from
39 coal-powered stations, transition to other energy sources.
40 So, that's something that really needs great awareness,
41 that it's impacting people's mental health in a positive
42 way and giving them a view towards the future.

43
44 I think the other thing is in relation to technology
45 and the value of human connection. So, people commonly are
46 talking to me about wanting to talk and connect with
47 others. I think, whilst technology provides great

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

4
5 Q. Drawing on your experiences, how should local
6 communities be engaged on the design, implementation and
7 delivery of reform efforts?

8 A. I think it's really important that the engagement is
9 meaningful. As I said, when I started people talked about
10 consultation fatigue, but that's not my experience in the
11 community. What I've heard people say to me is they want
12 to be heard, they want to be valued and then they want to
13 see action as a result of what they've had to say.

14
15 So I think there is a risk in listening and consulting
16 with the community if actually there isn't change as a
17 result of what the community is looking for. So, I think
18 that engagement has to be meaningful, it has to value what
19 people say.

20
21 It has to be cognisant of the experience in which
22 people are living their lives. Again, just yesterday I
23 spoke with a fellow who was talking about the cost of
24 getting his licence, and it wasn't something that would
25 ordinarily have struck me, but his mother is blind. So, it
26 cost him \$7,000 to get his licence because he had to pay
27 for private driving lessons.

28
29 So I think it's being conscious of people's day-to-day
30 lives, what they're facing, to listen and engage and give
31 value to their experience and to listen openly and not make
32 judgment.

33
34 Again, another person said to me she was receiving
35 family violence support, and she felt judged because she
36 was needing to get services to address issues of family
37 violence, and she felt that there was a judgment of her
38 that she needed to get those services. So, I think it is
39 that non-judgmental approach to people to listen to what
40 their suggestions are.

41
42 Q. One of the other things you mention is reaching out to
43 communities at times and locations that suit them.

44 A. So, what I found is, my job is certainly not a 9 to 5
45 job. So, I go to community events, I go to locations where
46 I know people gather. And, this is talking about how
47 people recover from events as well, that there was a

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

4
5 It just so happened that at that event they also had
6 music, the Strzelecki Stringbusters. So they had again
7 that social activity and people coming together to address
8 an issue. It just so happened at that event they ran out
9 of sausages because there were so many people that came to
10 the event and, of course the butcher was there, it's a
11 regional area, he was able to go down the street and go and
12 get more sausages and they could cater for a lot more
13 people.

14
15 But it is about going to those locations where people
16 already are, rather than requiring them to come to
17 something else.

18
19 MS COGHLAN: Thank you Ms Anderson. Chair, do the
20 Commissioners have any questions?

21
22 CHAIR: Q. I've just got one. Thank you for giving us
23 that overview. We heard this morning evidence about the
24 importance of the broad range of social determinants of
25 mental health being taken into account and the value of
26 schools becoming part of a community hub and their Our
27 Place model, and we heard that Morwell is one of the
28 potential sites.

29
30 Just noting the fact that your Assembly is largely
31 made up of members with a health focus and local council.
32 What do you think of the value of a broad approach and
33 understanding of the planning, I guess, across the range of
34 services systems and the advice you could give in your role
35 beyond the health service provision?

36 A. Very important people coming together from lots of
37 different perspectives, and actually in the membership of
38 the Assembly, so separate from the board, there's about 45
39 people in the membership of the Assembly and those people
40 come from a range of different areas: some of which come
41 from education, some come from other agencies like the EPA
42 and others are community members with whatever experience
43 they have.

44
45 One of the programs that actually was initiated in
46 Morwell was the Nurses in Schools, and that came from the
47 identification of an issue that the school had around a

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

4
5 And what that meant in that area, again where there is
6 generational disadvantage, so people's complexity in their
7 lives, they've just got so much going on, where they've got
8 kids needing different medical appointments and they might
9 have their own health issues, it was a way that the kid's
10 health would be prioritised through the school.

11
12 So the nurse came in and was able to support children,
13 then that moved through to dental programs, but it's also
14 moving through to relationships between the nurses and the
15 parents. So, now the parents feel comfortable going and
16 seeking out health services, but then that also moves
17 through to parenting programs and other supports and
18 linking the parents through to the school so parents are
19 not feeling as though that's a foreign environment and can
20 be intimidatory towards them.

21
22 CHAIR: Thank you very much.

23
24 MS COGHLAN: Thank you, Chair. May Ms Anderson please be
25 excused?

26
27 CHAIR: Yes, thank you very much for your statement and
28 your evidence today, Ms Anderson.

29
30 **<THE WITNESS WITHDREW**

31
32 MS NICHOLS: Commissioners, the next witness is Scientia
33 Professor Helen Christensen. I call her.

34
35 **<HELEN MARGARET CHRISTENSEN, affirmed and examined:[2.32pm]**

36
37 MS NICHOLS: Q. Professor Christensen, thank you for
38 joining us from Sydney today.

39 A. It's a pleasure.

40
41 Q. Are you a Director and Chief Scientist at the Black
42 Dog Institute?

43 A. Yes.

44
45 Q. Are you a Professor of Mental Health at the Faculty of
46 Medicine at the University of New South Wales?

47 A. Yes.

1
2 Q. Are you also the Chief Investigator for the Centre of
3 Research, Excellence in Suicide Prevention and also a
4 National Health and Medical Research Council Elizabeth
5 Blackman Fellow in Public Health?

6 A. Yes.

7
8 Q. Does your research focus on using technology to create
9 evidence-based innovations to prevent depression, anxiety,
10 self-harm and suicide?

11 A. It does, yes.

12
13 Q. Between 2005 and 2012, you were the Director of the
14 Centre for Mental Health Research at the Australian
15 National University?

16 A. Yes.

17
18 Q. From 2017 to 2018, you were a non-executive director
19 at the organisation called "R U OK?"

20 A. Yes.

21
22 Q. We do have a copy of your extensive CV, so I won't ask
23 you any more questions about yourself, but I will ask you
24 about Black Dog. Can you please tell the Commissioners
25 what Black Dog is and what its aims are?

26 A. The Black Dog Institute consists of around 400 people.
27 What we try and do is take research evidence and
28 evidence-based practice and put it into practice in
29 communities, including schools and workplaces. So, it's a
30 translation of what we know from the research evidence into
31 practice.

32
33 Q. Does it particularly focus, at least in part of its
34 work, on online and app-based interventions which use
35 cognitive behavioural therapy to deliver interventions,
36 particularly to schools?

37 A. Yes, it does.

38
39 Q. How is Black Dog funded?

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

1
2 The total amount of government funding we have is much
3 lower than the amount of money that we get from
4 philanthropy or competitive research grants.
5

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

9 A. Yes.

10
11 Q. Is that an unusual thing in this field of endeavour?

12 A. No. I think, if you're looking at medical research,
13 gold standard way of doing research is to employ a control
14 group and compare that with an intervention. It may be a
15 little bit unusual to do this on app-based and online
16 programs, but our total commitment was, we want to show
17 this is as good as medication and have exactly the same
18 level of rigor as you would normally apply to any
19 psychiatric intervention.
20

21 Q. I'll ask you about your particular programs shortly,
22 but on the point about it being as good as medication, what
23 have you found?

24 A. Well, the evidence not directly from us but from a
25 large meta analyses, shows that cognitive behaviour therapy
26 is as effective medication, and indeed that online
27 programs, especially those with some blended component with
28 a human are as effective as medication.
29

30 Q. Is that particularly to treat anxiety or depression,
31 or both?

32 A. Both.

33
34 Q. And the research specifically concerns those two
35 conditions?

36 A. Yes.
37

38 Q. When you say "as effective as medication", you mean
39 medication directed to those two conditions?

40 A. Yes, antidepressant medication.
41

42 Q. When you referred a moment ago to "a blended human
43 component", what did you mean by that?

44 A. Yes. By that I meant that, you can have completely
45 stand-alone app and internet interventions, or you can have
46 some amount of human support in provision to the person as
47 they work through the program. So, you might not

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

7
8 Q. Before I go to how you implement them, can I ask you
9 to illustrate these kinds of interventions by talking about
10 one of your programs, namely SPARX-R?

11 A. SPARX-R is currently on trial in New South Wales,
12 we're trying to approach 20,000 young people. The goal of
13 it is to show that you can do prevention programs at scale
14 in Australia.

15
16 So, if we are successful, we would have one of the
17 largest trials, probably the largest trial in the world.
18 Our approach is that, rather than do it by testing
19 something in the clinic, we try and test it in the wild, so
20 in fact the laboratory is a real world setting.

21
22 So, if a school agrees to be part of one of these
23 large trials, we will set up a time and place to go and
24 talk to whoever's in charge of the mental health of the
25 school, arrange for the time in which we'll, say, implement
26 a six-week program. We will get consent from both the
27 student and the parent beforehand, and then we turn up on
28 the day. We would load up the particular app and they
29 would have already provided consent and they would undergo
30 the program.

31
32 So, SPARX-R, which was developed in New Zealand, is
33 actually a game, and so, you choose a hero and you go
34 through this world where the aim is to get rid of
35 dysfunctional thoughts, which is the basis of cognitive
36 behaviour therapy. So, you know, you end up by arming
37 yourself with different strategies, and so then the person
38 would do that usually in the classroom curriculum for six
39 weeks, one hour a week. At the end of six weeks we would
40 assess them by an online questionnaire and then we usually
41 follow-up for 12 and 18 months.

42
43 Q. The purpose of the follow up is?

44 A. To determine whether the SPARX app has been more
45 effective long-term than a control condition. So, usually
46 we have a control condition, sometimes it's just normal
47 school activities, but sometimes it could be what's called

1 a placebo intervention.

2

3 Q. Can you tell the Commissioners about Sleep Ninja which
4 is another of your applications?

5 A. Sleep Ninja is an app that's on a phone, it's designed
6 for adolescents. The idea is that, if you can change kids'
7 sleep patterns, then you can actually lift their mood and
8 prevent depression. There was early work we did in a trial
9 with adults, that showed we had 1,200 adults from around
10 Australia. We did a program called Shut Eye and we showed
11 that it was as effective as cognitive behaviour therapy in
12 reducing both sleep symptoms and depression in adults, and
13 there was no contact between anyone except the app with the
14 person who was undergoing it.

15

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

23

24 Q. Can I talk to you about implementation in school.
25 What is the really promising thing about being able to
26 implement live in a school?

27 A. We have a captive audience, we have all the kids
28 usually - not all the kids, but a lot of kids. In one part
29 of the program the kids are actually screened for mental
30 health risk, including a question on suicide ideation, and
31 we have a duty of care around the counsellor and the GP
32 within that school region, and so, all kids who screen at
33 risk are actually followed up by the counsellor.

34

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

41

42 Q. Does that occur in the context of you running clinical
43 trials, or do you roll it out on a whole-school basis when
44 the app has already been proven, or both?

45 A. So, certainly in our clinical trials we have duty of
46 care, but we have another program called Smooth Sailing
47 which we're trying to run out now which does that in

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

6
7 Q. So, do they, for example, spend an hour a week all
8 doing the program at the same time, or is it
9 individualised?

10 A. Depends on the program and how we run it. So, Sleep
11 Ninja we did out-of-school hours, but most of them, if
12 they're part of the curriculum - and often schools will
13 agree that what we've developed as a resource is something
14 that's useful for the curriculum and fits the curriculum
15 and so it will be done within a PDHD class.

16
17 Q. How do you go about getting consent for the kids to
18 participate in these trials when they are trials?

19 A. We approach the school and then usually in conjunction
20 with the school we have access to the kids to invite them
21 to be part of the project, and at the same time we have
22 access to the parents. A big trial that we're just
23 starting, we've done all the consent for this, it's only 14
24 schools but it's about to start on Monday so it's at the
25 top of my mind. Around about 70 per cent of kids and their
26 parents will agree to do the project.

27
28 Q. How have you gone with dealing with the Education
29 Department in New South Wales, has that been a positive for
30 you?

31 A. It's been a very positive experience. We've had a lot
32 of support from them, and we have a very good relationship
33 with them. Because, apart from the trials that we do and,
34 as I said in the statement, we have a lot of exposure to
35 schools, our programs are generally valued, I think Black
36 Dog has a high trust component, and so, as a general rule
37 we do get invited by schools many, many times to come in
38 and deliver a particular program: whether it's volunteers
39 talking to their kids, whether it's around mental health
40 literacy, whether it's about suicide prevention. So, our
41 engagement with schools is very good at very high levels in
42 schools as well.

43
44 Q. We talked about effectiveness earlier on at a very
45 general level, these types of programs being as effective
46 as medication, can you say a little bit more about the
47 effectiveness of these programs that you've rolled out in

1 schools in Australia?

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

13

14 Q. Can you tell the Commissioners about iBobbly, what it
15 is and how it evolved?

16 A. Yeah, so iBobbly is an app that was co-designed in an
17 indigenous community in Broome. It was a fantastic project
18 to be involved in, there was so much enthusiasm from the
19 people involved.

20

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

28

29 We ended up with this app called iBobbly and we gave
30 it to 61 young people within the Broome community, all over
31 actually; long, long way. There's actually a nice photo of
32 a picture of the app being used in a ute with a dingo so it
33 was kind of very, very out there. We found that it
34 resulted in a 42 per cent reduction in depression and a
35 28 per cent reduction in suicide ideation; that it was well
36 accepted by the community, and that the drop-out rate was
37 3 per cent.

38

39 Q. Has that been rolled out further?

40 A. No. We've done a second trial of around 400 young
41 people around Australia. At present we're trying to seek
42 roll out from the Federal Government for it.

43

44 Q. Where would you like to roll it out? How widespread
45 would you like that to be?

46 A. Across Australia. We realise that part of what we
47 have developed skills in is implementation, and it's not

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

9
10 Q. What features of that intervention made it
11 particularly effective?

12 A. It was co-designed, it was done in conjunction with
13 the local suicide prevention agency called Alive and
14 Kicking Goals. When people saw it, indigenous people saw
15 it, they knew it was designed for them.

16
17 And, you know, we have a lot of qualitative data
18 saying what they actually said about it and, you know, they
19 said things like, "This app, him deadly" and, you know,
20 really, really showing that for them this was something
21 that they used. Because they do use a lot of social media
22 and technology, and we designed the app so that you didn't
23 have to have internet in order for it to work: you could do
24 it off-line and then the data was uploaded later.

25
26 Q. For suicide prevention, how significant is it that the
27 intervention is delivered by way of an app?

28 A. Well, an app is one part of the picture. So, if you
29 think about the effective strategies that are required for
30 suicide prevention, I think the best way to describe it
31 from our perspective was that we did have this centre for
32 research excellence in suicide prevention that focused on
33 technology.

34
35 We then got a big grant from the Ramsay Foundation,
36 Paul Ramsay Foundation, in order to do a full
37 implementation across four sites in New South Wales, and at
38 that point we realised that the technology is the key to
39 being able to scale effective strategies. So, it's not
40 really about the apps themselves, it's how you employ them
41 within a bigger scheme about what can be done across the
42 intervention space.

43
44 Q. When you say "scale", do you mean enabling the
45 intervention to reach a large number of people in a short
46 period of time?

47 A. Yes. One of the things, say, about suicide prevention

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

8
9 Q. Can I ask you a bit more about the suicide prevention
10 systems that Black Dog is involved in. You've mentioned in
11 your statement that Black Dog has developed a suicide
12 prevention intelligence system. What is that?

13 A. Yes. So, what we found was that, we needed to
14 evaluate whether our large-scale intervention was going to
15 be effective, and we found that it wasn't very easy to get
16 the research data that you needed: so Coroner's deaths,
17 ambulance data, police data, hospitalisations, they all
18 have a place to play in being able to provide you with the
19 information of what's actually happening on the ground.

20
21 So, we developed this system which brings together all
22 of those datasets and geospatially maps it into a local
23 area, so we can see where deaths occur, where the risk
24 areas are, where the hot spots are. We also bring in data
25 about health professionals, so we can say where there's a
26 missing group of health professionals within certain
27 geographical areas.

28
29 It also allowed us, by bringing all this data
30 together, to start to think about what other things people
31 need on the ground to solve suicide. We developed what we
32 call Suicide Audits which is, if you like, the intelligence
33 that comes from the data to be able to assist. So, for
34 some people in certain councils or areas, they weren't
35 aware of where people were dying, so we were able to
36 provide information about particular areas.

37
38 We were also able to provide information about what
39 could be done, what are the strategies that you can do to,
40 say, reduce deaths near cliffs or so on. That was
41 delivered directly to the suicide prevention agencies or
42 groups who were working on the ground in various primary
43 health care networks.

44
45 So, I guess it's a mixture of having worked very hard
46 to bring data together in a way that had never been done
47 before, and then to use it in a way to try and answer the

1 questions that people on the ground had, which is where are
2 people dying, who can help, has something just happened,
3 though we do have trouble finding timely data.
4

5 Q. So, am I right in thinking that a fundamental plank of
6 that strategy is that it's place-based, and that it uses
7 data about a number of things that intersect in relation to
8 the place; is that right?

9 A. So, the actual data system allows us to provide good
10 information to the community. The life-span project brings
11 together nine strategies to hopefully bring around some
12 sort of synergy, because just doing one thing alone, that
13 just doesn't have enough impact.
14

15 Q. Can we stay with the data in the place-based strategy
16 for a moment. How is that rolled out? You mentioned the
17 primary health care networks before, so can you perhaps
18 give us an example of how this application would work in a
19 local area through a Primary Health Care Network?

20 A. I guess I'm just making a distinction here between
21 what I call our high fidelity trials and the --
22

23 Q. I see. Okay.

24 A. So essentially, we would commission a particular
25 Primary Health Care Network, or Local Health District, to
26 undertake a number of activities that we had suggested were
27 required. We would then fund suicide prevention
28 coordinators to work with collaboratives or other suicide
29 networks already, and then we would provide as much
30 possibly that we could in terms of the resources needed:
31 so, how do you do aftercare? What sort of programs should
32 you be doing in schools? Here's a media strategy and so
33 on. And then that collective would work on the
34 implementation of that particular strategy.
35

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

39 A. Yes.
40

41 Q. And what resources are available in coordinating them?

42 A. Yeah. I think it's partly top-down, bottom-up,
43 because you want to encourage the take-up within the
44 community itself. So, one of the strategies is means
45 restriction, which means making sure people are safer than
46 they were. And so, the audits are around that particular
47 strategy.

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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

1 on.

2

3 Q. And what - go ahead, sorry.

4 A. I was going to say, it is a problem. Like, we all
5 have these suicide datasets that are kind of locked up and
6 not integrated. So, we're doing our best, but yeah, there
7 really is a difficulty in getting timely data to people on
8 the ground.

9

10 Q. What's been the rate of uptake of the system?

11 A. Well, we started using the Paul Ramsay donation.
12 We've added another site, which was the ACT, which is
13 paying for us to do the actual site because we've spent all
14 the money on the other four sites, and now the kind of
15 general model of LifeSpan is being used in 29 sites across
16 Australia.

17

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

22

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

29

30 Q. What's the general geographical reach of a region?

31 A. So, for the high fidelity sites, it varies from
32 150,000 to about 300,000. So, the actual sites for the
33 full trial are around about 850,000.

34

35 Q. And that's the population measure?

36 A. M'mm.

37

38 Q. Can you clarify what's a high fidelity site?

39 A. Okay, so the high fidelity sites are the ones in which
40 we've had the Paul Ramsay Foundation. So, we have
41 coordinators that we pay basically. The way it worked was
42 that we put out expressions of interest to Primary Health
43 Care Networks or Local Health Districts, and they then
44 applied to be able to undertake the program. So, there was
45 a lot of buy-in and enthusiasm.

46

47 Q. What have you found out about its effectiveness so

1 far?

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

8

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

16

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

21

22 Q. So they perform control groups for each other?

23 A. Yes, and also, we of course have all the data from the
24 rest of the areas as well which can also form a second
25 level of control.

26

27 Q. Thank you. Can I ask you about digital phenotyping?

28 A. Yes.

29

30 Q. What is it?

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

38

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

47

1 Q. What are the signals that can be detected by the
2 mobile phone?

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

10
11 We don't do anything to do with social media,
12 Facebook, Instagram, Snapchat, any of those sorts of
13 things, so it's very specific kinds of signals.

14
15 Q. What do those signals reveal about a person's mental
16 state?

17 A. Well, that's the question and that's why we're doing
18 the research.

19
20 Q. What's the hypothesis then?

21 A. We do know certain things: for example, we know that
22 people who are depressed stay at home more and are less
23 active.

24
25 But the real key question is, for an individual, can
26 you tell that they're becoming depressed? Because that's
27 just a general group difference, and we want to actually be
28 able to tell at an individual level, is there something
29 that those signals in combination are able to tell us about
30 how that person's going? Or even tell the person
31 themselves, not just us.

32
33 Q. I was just about to ask you that. Who gets the
34 information and how is it used?

35 A. So, at the moment we get the information at Black Dog.

36
37 Q. So, is that on the basis of consent by participants in
38 a trial?

39 A. Yes. So, for example, the trial that's starting next
40 week, we have consent from both the parents and the
41 children about that data being collected. We also allow
42 them the opportunity to say what sort of data they're
43 comfortable providing to us. So, they can opt out, for
44 example, the location data.

45
46 With the location data in terms of privacy, we have it
47 so that we only get it as an average over seven days at the

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

3
4 Q. This is very much cutting-edge science, would you say,
5 in this field?

6 A. Yes.

7
8 Q. So, why is Black Dog pursuing it? What potential do
9 you see in it?

10 A. Well, I think Black Dog is a medical research
11 institute, we're very interested in important questions
12 like, can you predict suicide? That's essentially what
13 motivates us to do it.

14
15 Also, in Australia we have a lot of trust, so people
16 are prepared to give us data. We have a very high quality
17 science leadership in this area as well, so it's really
18 important to ask that. If people are going to be using
19 these signals, they're meaningful, and that, you know,
20 you're not getting people ripping people off or, you know,
21 there's an authenticity about actually putting it under the
22 microscope, putting it through human ethics, making sure
23 everyone's consented, and that makes it something that we
24 really would like to do and do well.

25
26 Q. Just back on how those kinds of signals would be used,
27 do you need a third party to interpret the signals? Is
28 that how the model would work?

29 A. Yes. You need more than a third party really. You
30 need - it's sort of like this huge volume of data comes and
31 how meaningful it is or what particular aspect of it is
32 meaningful is really essentially not that well-known,
33 because people don't use it in a standardised way. It's
34 been done, but with very small samples.

35
36 So, when you have large samples, then you employ
37 artificial intelligence to be able to help. We're actually
38 take it two ways: one is artificial intelligence, so we're
39 working with our partners at Deakin University with
40 de-identified data to see if there's anything that can be
41 pulled up from those signals when a machine does it as
42 opposed to a human.

43
44 Then we're looking at the science of it by saying
45 things like, well, when people are depressed, they slow
46 down, and so, is there something in a rapid change in their
47 speed of doing a particular thing that indicates to us

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

6
7 Q. Do you know what the length of time will be until you
8 start to get some meaningful results out of this project?

9 A. Well, certainly over the next six months we'll have
10 enough data to be really doing the artificial intelligence
11 side of it. But this is - to me, it's like DNA. It took a
12 long time for DNA signals to be made interpretable, and
13 this is just really the beginning of the same process.

14
15 Q. On a slightly different form of technology, you've
16 said in your statement that Black Dog's currently working
17 on a project that uses CCTV with artificial intelligence to
18 analyse behaviour in relation to suicide risk. What's that
19 project and how does it work?

20 A. This really arose from the idea that, I went to a
21 visit to - not that it's entirely my idea, I don't want to
22 give that impression - but I went to Rose Bay Police
23 Station and we were given a tour of the Gap Park which has
24 a high incidence of deaths. They do have CCTV footage, but
25 that CCTV footage isn't used until after the event, and
26 it's actually only turned on when a person goes across the
27 fence.

28
29 So, meanwhile they are still filming all the time, if
30 you know what I mean, around the park, it's just not being
31 looked at. So we have a partnership with Deakin University
32 and there's lot of AI in surveillance in, say, airports and
33 picking up anti-social behaviour - not that I'm trying to
34 make a comparison between suicide and anti-social
35 behaviour - but for example, what the technology's based on
36 is seeking anomalies, so what is normal and what isn't.

37
38 And so, if you think about the Gap Park, there will be
39 some people who might have anomalous behaviour, and whether
40 that is somehow going to help us know that person is a
41 particular risk; you know, whether it's something like
42 maybe pacing or just sitting there and not doing anything
43 for hours.

44
45 I think there was interest from the police and the
46 Waverley Council. We tested the idea with consumers to see
47 whether they thought this was, you know, a reasonable thing

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

5
6 Q. So, would that inform two things: both potentially
7 intervention when someone is perhaps contemplating suicide
8 if the data is made available in real-time, and also,
9 perhaps interventions by preventing means at particular
10 sites?

11 A. I think that's the idea, that we want to see whether
12 at least it is possible to get earlier to a person who
13 might be at risk.

14
15 Q. So, you would have to link the data up with the means
16 of providing immediate support?

17 A. Oh, yes, and, you know, if you know anything of the
18 Gap Park, there's a lot of people at the Gap Park. There's
19 often a lot of emergencies. I'm not sure of the exact
20 number, but every two or three days there would be an
21 emergency at the Gap Park, so people are very aware that it
22 is a hot spot for intervention.

23
24 Q. Can you tell the Commissioners, please, what is RAFT,
25 a digital app that you're trialling to deliver help after a
26 suicide attempt?

27 A. So RAFT is developed by Mark Larsen at Black Dog
28 Institute, it's a very short intervention. It's both a
29 safety planning app that also offers intervention,
30 psychological intervention, and we deliver it to people who
31 want to participate in the research in a number of
32 hospitals around Australia. So, they sign up to have RAFT
33 and we're just evaluating whether RAFT does improve their
34 mental health and does prevent them from making a
35 re-attempt.

36
37 Q. Can I ask you a more high level question? What's your
38 view about the extent to which we in Australia know much
39 about the effective means to prevent suicide?

40 A. So, really a very big question. I think that the
41 overseas experience shows that we're all struggling with
42 this. I think the World Health Organisation, European
43 Alliance Against Depression, have pretty much come up with
44 a similar kind of view on it based on evidence that you
45 really need to put all these strategies together: it has to
46 be both health, it has to be social and support, and to
47 ignore the community is really - or the public health side

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

2

3 We do know that a lot of broad factors are extremely
4 important. I think this is well-known, that unemployment,
5 a 1 per cent increase in unemployment results in a
6 0.07 per cent increase in suicide. We know from
7 retrospective hospital data that, if you have more
8 strategies in place from a hospital perspective in terms of
9 outreach and so on, then you're more likely to get a better
10 outcome for those particular district hospitals, so I think
11 we do know enough to be able to be doing a lot in the
12 space.

13

14 One of the most interesting - not interesting, but one
15 of the most dramatic things that I think we've learned
16 recently, is that, talking about suicide in a celebrity, or
17 13 Reasons Why, does result in an increase in suicide rate.
18 So, there's been two recent papers showing that, for
19 example, Robyn Williams' death, there was an 8.9 per cent
20 increase in male deaths for the next two or three months in
21 the US as a result of modelling which, you know, modelled
22 expected death rates and then death rates after his death.
23 I think it was August, for the next two months there was an
24 increase.

25

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

35

36 Q. Is there research about the kind of
37 counter-interventions that can be effective when something
38 happens that is unplanned and can't be controlled by, say,
39 having media guidelines because it just has occurred and is
40 known about?

41 A. That's a really good question, I don't know.

42

43 Q. Is that something that's worth some research, do you
44 think?

45 A. Yes, I think that's really interesting to see. I
46 mean, we do know how kind of trauma can be handled in
47 different communities and so on, but with that social media

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

5
6 Q. Can I ask you about a different topic and that is
7 technology and e-Health. What's your view about the
8 effectiveness of it and the utility of using it in
9 Australia at its current status?

10 A. I think it's highly effective. In the trials that we
11 run it's highly effective. The question is, does it
12 transfer into the wild?

13
14 Q. In the?

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

21
22 For example, in the Netherlands and in Sweden where
23 it's similarly classed as something like Medicare, or you
24 know, it's just part of the system and this is what you can
25 get. Even in the UK now, I think through the IAPT, which
26 is a process of getting psychological help to people
27 through the trusts, e-Health is beginning to have some more
28 impact. It's always been regarded as one of the
29 inventions, but it is actually starting to really pick up.

30
31 The advantage of technology is not just that it could
32 be as effective especially in that blended way I talked
33 about before, but because of its scalability. So, for
34 people who can't have access, when there's no health
35 professionals, then automated CBT is highly effective. But
36 we don't seem to have converted this knowledge into
37 something that is just part of how we provide health
38 services now, and I think that's a real shame, and I think
39 there's probably not enough attention to it and there's not
40 enough support for industry to really embrace it and put
41 financial dollars behind it.

42
43 So, we still have, if you like - I wouldn't say a
44 cottage industry because I think that a lot of the apps
45 that we have have quite a large range, but in the health
46 system it just doesn't seem to be picking up.

1 Q. What are the particular barriers to implementation?

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

11
12 So, I think in general practice it's around the way
13 we've structured general practice. In the internet,
14 directly through the internet we have a number of different
15 providers. I think people think that internet
16 interventions are just free. In fact, they require
17 updating all the time, all the software needs to be
18 improved, so there's no kind of investment in that that I
19 see. So, I think there's lot of different sorts of
20 barriers.

21
22 I think there's also an attitude that it's not good
23 enough, that it's inferior to other interventions. I've
24 heard people with lived experience saying that all the apps
25 are hopeless and so on and so forth. So, I think that part
26 of the problem is us, and there are a lot of not so great
27 apps out there, but there's also this expectation that, if
28 it's an app, it has to be slick. Rather than, if it's a
29 health intervention, it's a completely different perception
30 of what your expectation is from a particular technology
31 solution.

32
33 Q. Is there anything else you'd like to say that we
34 haven't addressed about the importance of digital
35 interventions in preventing mental illness?

36 A. Obviously, I think it's the way to scale. I think the
37 Health and Safety Commissioner's looking at it at the
38 moment in terms of, how do we make sure that we get high
39 quality products? I think that's about it, thanks.

40
41 MS NICHOLS: Thank you, Professor. Chair, are there any
42 questions from the Commissioners?

43
44 CHAIR: Professor McSherry.

45
46 COMMISSIONER MCSHERRY: Q. Thank you very much for your
47 evidence today and for your comprehensive statement. I

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

3
4 We know that personal health information has been
5 referred to as some of the most sensitive data. So, do you
6 think there might be a barrier in terms of privacy issues?

7
8 Certainly we saw with My Health Record a number of
9 people with lived experience decided to opt out because
10 they were concerned about third parties perhaps accessing
11 information. How do you go about combatting that
12 perception or that barrier in reality?

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

18
19 So, I really think ultimately it's going to come down
20 to people owning their health record so that they have
21 control over it. On the other hand, we don't get too much
22 negativity from schools, or from workplaces where we are
23 introducing some of this app technology, so I think people
24 are quite willing to do it if it possibly isn't in the
25 health system and possibly if they're convinced that
26 they're giving the data to a trusted organisation that
27 knows how to look after it.

28
29 Q. The other question I have: I know in the criminal
30 justice field there's been some concern about algorithms
31 that are used for risk assessment tools, that they may be
32 racially or culturally biased. So, I'm interested in the
33 AI side of things: how do you protect against sometimes
34 unintentional bias in the risk assessment tools that you're
35 developing in terms of children who may be at risk of
36 depression, for example?

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

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

6
7 Q. Just a final question too. I think that some
8 consumers with lived experience might be concerned about
9 what happens after the screening or surveillance, that
10 there might be a perception that coercive measures would be
11 taken to, you know, force the person into treatment or into
12 compulsory care. How do you guard against that?

13 A. I'm not sure how you guard against it in the public
14 arena where you've got commercial - that you're putting
15 out, but certainly it's at the forefront of our mind when
16 we seek consent and we seek ethics, to make sure that we're
17 totally out there about what the privacy considerations
18 are, what the consent is, what our governance is, what the
19 technical requirements are that are needed to make these
20 things safe.

21
22 So, for example, all of the apps and so on that we use
23 are only used in Australia, we only use data from
24 Australia. They're kept on a UNSW servers. They're
25 encrypted, and so on and so forth. So, I think that it all
26 comes down to people with lived experience being involved
27 in what data they want to share, how they want data used,
28 who owns their data, and I really believe that ultimately
29 we're going to have consumers owning their own data, or
30 people owning their own data, which I think is the way it
31 has to go.

32
33 COMMISSIONER McSHERRY: Thank you very much.

34
35 CHAIR: Q. Thank you, Professor. I just have two other
36 issues I'd like to clarify. The first one is in terms of
37 your apps and who you are trialling them with and using
38 them with.

39
40 We've learnt a lot in this Royal Commission, and it's
41 been raised about the importance of early intervention and
42 the growing prevalence of mental health issues in younger
43 children. In terms of the work that you've done to date,
44 how age-specific is it in terms of the interventions
45 through the schools, for example? So, that's the first
46 issue.

47 A. Yes. So, you've got this balance between screen time

1 and apps of course, and how young you want kids on screens.
2 All our work at the moment is in adolescents, so the
3 youngest would be around 13, or 12 to 13. One of our
4 positive psychology online programs, Fight Back, is
5 designed for 12 to 14-year-olds.
6

7 You know, it depends on what kind of condition you're
8 talking about. So, for example, autism and so on, I think
9 there's something to be said about providing opportunities
10 for kids to use apps or online programs, or machines, with
11 autism because they seem to learn and it's something that
12 they relate to. So, you don't want to make too much of an
13 age - should be this particular age or not.
14

15 Q. Thank you. I also noticed with the work that you were
16 talking about doing on suicide prevention, you talked about
17 the three things that you'd found to be very important was
18 about means, restriction, gate-keeping, training and
19 getting people into treatment.
20

21 Can I just confirm what you think is the effective
22 treatment that you would be advocating there? Is it CBT
23 like you have been talking about earlier in terms of the
24 apps or a broader range of treatments?

25 A. I think it's a broader range of treatments. Certainly
26 CBT is effective but DBT, Dialectic Behaviour Therapy, is
27 much more commonly used and the treatment is effective, but
28 I would be recommending in treatment people get proper
29 assessment by a psychiatrist, physical health assessment,
30 the whole range; it wouldn't just be an app with CBT on it.
31

32 We have, though, just finished a meta-analysis of apps
33 that are used in suicide prevention, stand-alone ones, and
34 we've found that they are effective. This is from
35 something like 16 studies around the world we've actually
36 looked at. If people use these apps from these trials, do
37 they actually have some benefit? Most of those apps use
38 CBT.
39

40 CHAIR: Thank you very much, Professor, and thank you very
41 much for your very comprehensive statement and your
42 evidence today.
43

44 MS NICHOLS: May I tender that statement, please? I
45 missed doing that. [WIT.0001.0062.0001]
46

47 CHAIR: Yes.

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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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