ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

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

On Thursday, 4 July 2019 at 10.00am

(Day 3)

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

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

1 MS NICHOLS: Good morning, Commissioners. Today and
2 tomorrow we'll focus and hear from witnesses who will urge
3 the Commission to focus steadily on measures directed to
4 preventing mental illness and intervening early in mental
5 ill-health, both in age and in onset.
6
7 You will hear evidence that there is good and growing
8 evidence that certain interventions have the potential to
9 lessen incidents' severity and the impact of mental
10 illness. Understanding and examining the ways to fully
11 realise this potential is important to the Commission's
12 work because of the potential impacts of prevention and
13 early intervention.
14
15 As the Commission has already heard in its
16 consultations with the community, "If only I was able to
17 get help sooner." That's been a pretty constant refrain.
18
19 The views of Victorians who attended the community
20 consultations have been echoed thus far in quite a number
21 of written submissions to the Commission. These include
22 submissions from service providers and academics who have
23 written about lost opportunities associated with the lack
24 of evidence-based prevention and early intervention.
25
26 Most mental health resources are directed to treat
27 people with established mental illness. People have asked
28 the Commission to consider evidence-based campaigns to
29 promote good mental health and increase mental health
30 literacy.
31
32 For example, one person has suggested that we should
33 educate people about mental illness from a young age,
34 saying, just like we educate people about diabetes, MS,
35 cancer and so on, we should be educating young people early
36 on in ways to maintain their mental health and prevent
37 deterioration.
38
39 Submissions have also emphasised the need for
40 investment in prevention targeted to high risk groups, in
41 particular people experiencing significant social, physical
42 and economic challenges.
43
44 In this context, as you will hear, prevention focuses
45 on reducing risk factors for mental ill-health and
46 enhancing protective factors before the onset of illness.
47 `

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Early intervention responds to individuals who are already showing signs of developing a mental illness or relapse after an earlier episode. This includes intervening early in life and targeting at risk children and young people.

While prevention and early intervention are different concepts, we have decided to cover them together in these hearings because of the close relationship between the two.

Many prevention initiatives in mental health rely on recognition of risk factors and early warning signs. The evidence will suggest that early intervention, especially early in life, may prevent the emergence of some severe illnesses years down the track, and intervening early when mental illness symptoms first occur can prevent or reduce further episodes.

With all this in mind, a key challenge for the Commission is to identify evidence-based prevention and early intervention approaches and to consider how they could be implemented in ways that are sustainable and effective reaching those in greatest need.

Over the next two days we'll hear from a number of very well qualified witnesses: the first is Georgina Harman who is the CEO of Beyond Blue. She will give evidence about the determinants of mental health, particularly social determinants, such as trauma, poverty, homelessness and things that are capable of being changed.

She'll give evidence about how prevention and early intervention approaches have significant effects in reducing behavioural issues, internalising symptoms and disorders such as depression and anxiety.

Professor David Forbes is the director of Phoenix Australia. He'll give evidence about psychological trauma and the types of disorders to which it can lead. His evidence will include a discussion about how much can be done in early intervention to mitigate some risk factors, including the implementation of trauma-informed care.

Melanie Hill is a mother of a 16-year-old daughter. Her daughter has had many diagnoses over the years since she was about 9 years old, the impacts of which have touched on just about every aspect of her life. Her

1 daughter's needs are complex.
2
3 Melanie will give evidence about a system that has
4 seemed to fail them at every turn despite their efforts to
5 get help. She'll say that early intervention, with the
6 whole family being involved, could have made a huge
7 difference for them.
8
9 She'll be giving evidence under a pseudonym and her
10 evidence will be the subject of a non-publication
11 order which prohibits identifying information from being
12 published.
13
14 Professor Helen Herrman is a very distinguished
15 academic and president of the World Psychiatric
16 Association. She will give evidence about mental health
17 promotion from a public health perspective.
18
19 Then, on Friday, you will hear from Amelia Morris.
20 Amelia is 21 years old and she will give evidence about her
21 difficulty accessing services in regional Victoria from
22 when she was about 15. She will say that, when she asked
23 for help as a young person, she felt like there was nothing
24 there.
25
26 Shaun McClare is the principal at Kalinda Primary
27 School. He will give evidence about his school and
28 initiatives called "Positive Education" which is the idea
29 that issues being experienced by young students, such as
30 anxiety and depression, can be curtailed or addressed
31 through initiatives built into the primary school system.
32
33 Dr Gaynor Blankley is the head of perinatal mental
34 health at Mercy Mental Health. She will give evidence
35 about mental health disorders that occurred during a period
36 of a woman's life, from preconception through to 12 months
37 post-partum. She will address the areas of community most
38 at risk of mental health problems in the perinatal period
39 and about the interdependence between maternal health and
40 infant mental health.
41
42 Dr Ric Haslam is the director of mental health at the
43 Royal Children's Hospital. He will give evidence about the
44 current infrastructure for youth mental health services
45 within the hospital context. He will also address the risk
46 factors for developing mental health issues in young
47 people, the importance of providing treatment, and the

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difficulties accessing child and adolescent services when needed.

Finally, Professor Pat McGorry is the professor of youth mental health at the University of Melbourne, and executive director at Orygen, the National Centre of Excellence in Youth Mental Health. He will give evidence about the many issues facing the mental health system and will opine about the elements he sees as critical to a well functioning mental health system.

His evidence will address early intervention which, for him, means intervening early in the course of mental illness, and disorders in order to improve the prospects of cure, recovery and better outcomes. His evidence will also address the role of Headspace and Orygen within the mental health system.

The first witness is Georgina Harman, and I call her now.

<GEORGINA HARMAN, affirmed and examined: [10.08am]

MS NICHOLS: Q. Ms Harman, with the assistance of the Royal Commission, have you prepared a witness statement in relation to your experience in the mental health arena?
A. Yes, I have.

Q. I tender the statement. Ms Harman, are you the CEO of Beyond Blue?
A. Yes, I am.

Q. Before that, did you help establish the National Mental Health Commission, of which you became the deputy CEO?
A. Yes, that's correct.

Q. Before that, were you a senior executive in the Commonwealth Department of Health and Ageing?
A. For my sins, yes.

Q. Did you have portfolio responsibilities including mental health, suicide prevention, substance misuse, cancer and chronic diseases?
A. That's correct, yes.

Q. Are you a director of Mental Health Australia and the

1 Victorian Pride Centre?
2 A. Yes, I am.
3
4 Q. Can I start by asking you, on the basis of your
5 experience and on the basis of research of which you're
6 aware, what are the correlations between socio-economic
7 factors, including poverty, unemployment, housing and
8 education, and the development of mental illness?
9 A. There's an incredibly strong correlation, we know, and
10 we call these things social determinants. I guess social
11 determinants are the conditions that we're born into, that
12 we live in, that we learn in, that we work in and that we
13 age in.
14
15 So, all of these factors really help determine how we
16 respond to life events, how we react to life circumstances,
17 the way we behave, the way we think, our psychological
18 health, as well as our physical health.
19
20 We know that the combination - or the presence or
21 combination of social determinants has a very strong link
22 to our psychological wellbeing. So, for example, if we are
23 born into poverty, if we are born into unstable housing, or
24 if we experience unstable housing throughout our life, if
25 we don't achieve our best education and we don't have the
26 opportunities to do that, if we experience childhood
27 adversity and trauma in particular, these are the things
28 that set us up for a life where we potentially don't have
29 the opportunities to achieve our best possible mental
30 health.
31
32 Q. I see. Does the evidence in relation to the
33 significance of social determinants differ according to the
34 type of mental illness being considered?
35 A. Look, we know that there's, for example, poverty,
36 homelessness, stable housing and education are very strong
37 determinants of how well we do in life and how well we do
38 psychologically.
39
40 So, for example, children who experience adversity in
41 childhood, and those experiences are linked to a higher
42 rate of psychological distress later in life. So, evidence
43 suggests that up to - people who experience childhood
44 adversity, up to a third of them, that direct experience is
45 linked to depression, anxiety and self-harming behaviours
46 later in life.
47

1 Q. Can I ask you, what is meant by the expression
2 "resilience" in the context of creating the best mental
3 health in society and in a person?
4 A. Resilience is one of those words that's used a lot,
5 it's bandied around, and I guess the best and simplest way
6 to describe resilience is our ability to bounce back from
7 adversity, but also to cope well during adversity.
8
9 So, it's not an aid, it actually can be taught.
10 You're not born with resilience or not born with
11 resilience. You can actually, through the circumstances in
12 which you live, through the adults and the environments in
13 which you live, you can either survive or thrive. So, the
14 ability to bounce back, the ability to live well through
15 adversity.
16
17 Some adversity we can't prevent - death of a family
18 member for example, a natural disaster, the loss of a home.
19 But there are things that we can prevent. There are things
20 that are part of our makeup as human beings, our ability -
21 how we think and behave and cope through those life events
22 can actually be taught, incredibly, simply and powerfully
23 by parents, by families, by schools, by early learning
24 services and by communities.
25
26 Q. When you say those things can be taught, do you mean
27 specifically through education in schools or something
28 else?
29 A. Very practical simple things in our everyday lives.
30 So, the people that have regular contact with children:
31 parents, families, awesome aunties like me. There are
32 moments where you can actually - there are teachable
33 moments, I guess we refer to them as.
34
35 So, for example, if a child doesn't do well in a test
36 in school. It's okay to say it's actually, you know, you
37 did your best, it's okay to fail, let's talk about how that
38 makes you feel and let's talk about how we support you to
39 do better next time. Talking out loud as an adult, we all
40 face adversities as well, and if we talk out loud about,
41 you know, that didn't go so well for me but it's okay, I'm
42 going to think about how I can cope with that better next
43 time.
44
45 And also, those professionals who work with parents,
46 families and children themselves. We conducted some
47 research with the support of the Parenting Research Centre

1 and ARACY, and not only to develop a consistent and common
2 definition and language around resilience, but also to
3 create advice for those professionals working with children
4 and families about how to not only do those - work with
5 families in those kind of teachable moments, but also to
6 design structured interventions themselves.
7
8 Q. Reflecting on the opportunity to provide teachable
9 moments, what does the evidence suggest about the
10 effectiveness of those kinds of strategies when perhaps
11 more fundamental things like housing and poverty are in
12 play?
13 A. Well, look, I think it's always better to prevent
14 adversity, but as I said earlier, often that is complex and
15 difficult; that is not an excuse for inertia, but if we can
16 protect the wellbeing and build the resilience of children
17 and families who are facing adversity, they are far more
18 likely to cope better with that adversity, to deal with the
19 stress of that adversity, and as we know, ongoing and
20 enduring stress is a major risk factor for developing a
21 mental health condition.
22
23 Q. Is it meaningful to consider resilience from the
24 perspective of a whole community?
25 A. Absolutely.
26
27 Q. As opposed to simply on an individual basis?
28 A. Absolutely. I did want to make the point that this
29 isn't about the person themselves and, you know, you have
30 to be resilient; you know, that puts I think an undue
31 emphasis and pressure on an individual and their
32 capacities.
33
34 The resilience of whole communities, the resilience of
35 communities to build through and bounce back from, for
36 example, bushfires or significant events in a school
37 community, suicides, the suicide cluster in a school
38 community, is incredibly important at an individual level
39 and at a population level.
40
41 Q. What are the markers of resilience in a community?
42 A. Things like the willingness and openness to talk about
43 this stuff and to do that confidently and openly; the
44 ability to identify and talk about what some of the signs
45 of stressors and emerging issues might be so that people
46 are aware of what they should be looking out for in
47 themselves and others; and obviously creating the pathways

1 to services and supports in the community and in the
2 service system when they're needed.
3
4 Q. You've spoken in your statement about the importance
5 of building resilience in the early years. What kind of
6 steps can promote resilience in children, from a practical
7 perspective?
8 A. In a practical perspective, it is making sure that we
9 have an integrated system that actually supports at a
10 population level and at an individual and a family level
11 the kind of structures and interventions that actually do
12 support childhood wellbeing resilience and mental health
13 issues. At the moment that system actually just does not
14 exist.
15
16 So, for example, we need schools and early learning
17 services to be literate in the signs and emerging symptoms
18 of mental distress and psychological and behavioural
19 issues, and we need the professionals working in those
20 environments to have, not only the knowledge, but the
21 confidence to be able to know what to do, what to say, how
22 to work with families, when to work with families, but also
23 to have the pathways very clear to them about how to
24 support those young people, children and families towards
25 more specialist support when they need it.
26
27 Beyond Blue is working with Headspace and Early
28 Childhood Australia on a national initiative called Be You,
29 which is being rolled out to every school and early
30 learning service in Australia. That was launched
31 last November and there's been a really positive uptake
32 already, including in Victoria.
33
34 I'd also say that, you know, workplaces are incredibly
35 important.
36
37 Q. Can I just stop you there, Ms Harman. Can we go back
38 to Be You and can we understand what it is?
39 A. Yes, of course. So, Be You is a framework, it's not a
40 program. Programs start and stop. This is a continuous
41 improvement framework that is freely available to every
42 single early learning service, primary school and secondary
43 school in Australia. It is funded by the Commonwealth,
44 delivered by a - developed by Beyond Blue and delivered by
45 Beyond Blue in partnership with Headspace and Early
46 Childhood Australia.
47

1 Essentially, the framework consists of very, very
2 simple to access, bite-size professional development for
3 educators that really gives them the dosage of knowledge
4 that they need - we're not trying to turn teachers into
5 counsellors or mental health professionals, but we know
6 that teachers are facing these issues in their classrooms
7 every single day, so we need to equip them with the
8 knowledge, skills and confidence and know how about how to
9 have - know what to look out for, know to have decent
10 conversations with children and families and know where to
11 connect them to get the help.
12
13 This is free online accredited professional learning,
14 so it links to the curriculum, it links to the national
15 standards for teachers.
16
17 Q. Is the intention to equip teachers to detect the signs
18 of mental distress, psychological distress?
19 A. Absolutely, and emotional and behavioural difficulties
20 in children as well. It's also supported by 70 real people
21 around the country, so it's not just in an online
22 environment.
23
24 Q. How many schools have signed on to that program?
25 A. As at 30 June, we've had over 4,600 schools around the
26 country, over 1,000 of which are in Victoria, and around
27 2,600 early learning services, so that's in five or
28 six months since launch.
29
30 Q. How will the success or the effectiveness of that
31 program be evaluated?
32 A. So we've started the evaluation already. The first
33 part of the evaluation was a formative evaluation: did we
34 build this thing, did we engage well, is it a product that
35 works for educators? Those findings have been very
36 positive. We're now in the middle of an implementation
37 evaluation which will start to measure not only is this
38 being taken up in the ways we want it to be taken up, but
39 engaging with the users of the framework, what's working
40 for them and what's not and how do we improve our
41 implementation of the product.
42
43 We're then also working with the Department of Health
44 in Canberra, they're designing and commissioning a longer
45 term outcomes-based evaluation which will look at the
46 markers of success. And, from my perspective, that needs
47 to look at things like attendance and engagement by

1 children and young people with schools. Those are very
2 strong markers of, you know, the fact that they're able to
3 cope with adversity, even if they - with or without having
4 a mental health issue. And, it's strongly correlated to
5 their educational outcome.
6
7 So, if kids are present at school, engaged and
8 attending, then we know they're more likely to learn, and
9 mentally healthy kids learn better.
10
11 Q. Thank you. Do you know the period of time over which
12 the longer term evaluation will be tested?
13 A. Well, we have - the measure is funded for another -
14 the program is funded for another two years. That
15 evaluation commissioned by the department is sort of
16 underway in terms of its design and methodology. My hope
17 is that this is an initiative that is funded for the
18 long-term. This is the kind of long-term population
19 universal behaviour change program that actually needs
20 long-term investment.
21
22 And, whilst this is a Commonwealth funded initiative,
23 my urging to this Commission and to Victoria is to not
24 duplicate it. This is being funded by the Commonwealth,
25 but to plan complementary investments that actually deal
26 with and address some of the things that Be You uncovers.
27
28 So, for example, we know that educators are highly
29 stressed themselves, so psychological supports for
30 principals, teachers, early learning professionals, but
31 also additional and more accessible, more specialist
32 services for children and young people.
33
34 Q. Yes, thank you. Has Mental Health Australia
35 commissioned work through KPMG about the cost savings that
36 would be achieved by reducing mental health issues in
37 childhood?
38 A. That's correct, and that was a report that was
39 released last year, and from memory that report found that,
40 if we were to better address mental health issues in
41 childhood, we could potentially save $48 billion a year.
42
43 Q. And that was on a national level?
44 A. Yes, that's correct.
45
46 Q. Can I just return you to the question of social
47 determinants. On the basis of your experience, including

1 through Beyond Blue and your previous roles, what do you
2 say about whether there is sufficient emphasis in mental
3 health policy on dealing with social determinants of mental
4 health?
5 A. I would say there is insufficient emphasis. I think,
6 where we go to automatically through policy, whether that's
7 at a state or a national level, is the health sphere, and
8 we carve people up into bits of their lives and bits of
9 their experiences and bits of their needs.
10
11 We forget about the fact that this needs an absolutely
12 joined up coordinated and integrated response, not only
13 just within a jurisdiction: through justice, housing,
14 education, health, but also between the Federal Government
15 and state and territory governments.
16
17 We need data that actually tells a picture and that is
18 linked so that we can measure how people are doing across
19 all parts of the system, and we need to re-engineer the
20 system so that it is actually about people. Quite often
21 the big investments in mental health are led and designed
22 around providers, so people have to go to where providers
23 are, and the major investments in Medicare through the
24 Better Access Scheme, the PBS, giving people access to
25 affordable medications, and then the state and territory
26 specialist mental health systems do not talk to each other.
27
28 Q. We'll come back to that in a little while, Ms Harman.
29 One of the things you've raised in your statement in this
30 connection is the focus on short-term funding and the
31 propensity to invest in pilots and then not plan for their
32 scaling. Can you elaborate on that?
33 A. Yeah, we had someone called a pilotitis yesterday. We
34 tend to - so, can you imagine any part of a supply chain in
35 which a supplier actually only receives 12 months worth of
36 funding? How can you possibly plan, from a workforce
37 perspective, but more importantly from a service continuity
38 perspective, to create evidence, to create efficiencies, to
39 create integration: you just can't do that as a business,
40 let alone as a service provider. I mean, that is the
41 experience of many, many NGOs and community-based mental
42 health providers in Victoria and across the country.
43
44 We also tend to throw money at good ideas, and that is
45 a good thing, but we pilot them and then we don't
46 systematically, from the beginning, plan for, if they do
47 show promise, to have them scaled up; whether that's across

1 a state or more broadly.
2
3 So, we tend to start things, they show promise, and
4 then they either die a long strangulated death or they
5 disappear completely, or they limp on trying to patch
6 funding together. And we know that there are some really
7 fantastic emerging new models of care out there that really
8 need an injection of long-term funding certainty,
9 notwithstanding the fact that they need to prove themselves
10 as well.
11
12 But putting around them, again, a measurement and
13 evaluation framework from the beginning, and funding that
14 properly, a mixed method of evaluation. So, not just RCTs
15 which come up with a binary, did this work, yes or no, but
16 mixed method that includes the voices of people with lived
17 experience, so that we can not only answer the question,
18 did this work, yes or no, but why didn't it work or why did
19 that work so well and how can we do this better, how can we
20 continually improve?
21
22 Q. Thank you. Perhaps turning that question around.
23 What in your experience are the key features that likely
24 make resilience measures successful?
25 A. That likely make resilience measures successful?
26
27 Q. Successful, yes.
28 A. Again, it goes back to social determinants. It goes
29 back to the issues of a contributing life that Janet
30 Meagher was talking about yesterday. It's about the best
31 start in life, it's about having trust and comfort and
32 routine, and stability from the moment you're born, and
33 families, in particular those families who do face
34 adversity, having, you know, person-centred - that's one of
35 those phrases that we throw around a lot.
36
37 Q. It is.
38 A. But having a suite of services and supports, not just
39 medical services, but that actually are about saying to
40 that family, actually what do you need? What would make a
41 difference for you? What are the issues that are troubling
42 you the most? And how can we support you and do the hard
43 work around you to join up a package of supports that
44 actually help you as a family to overcome those
45 adversities?
46
47 A great example is, you know, Housing First model.

1
2 Q. Can you talk a bit about that?
3 A. Of course. So, let's get people in stable homes, and
4 often that is the point at which, when you have an address
5 and when you can afford to pay the rent or you can afford
6 to pay the mortgage, you have an address and you can use
7 that address to put on a resume and apply for jobs, you can
8 give that to Centrelink, you can give that to your social
9 worker.
10
11 So, let's get people in stable affordable housing and
12 then start to work with that family or that person to
13 resolve and deal with the other issues in their life that
14 might be causing them vulnerability: whether that is access
15 to good work, whether that is a health issue, whether that
16 is a mental health issue.
17
18 And again, those responses don't always need to be
19 medical responses. They can be about creating social
20 supports for people, they can be about providing low
21 intensity interventions provided by a new workforce that we
22 call coaches through Beyond Blue's New Access program.
23
24 Q. Can I just ask you what coaches are in that context?
25 A. Of course. So, Beyond Blue, about seven or
26 eight years ago, took a model that was proving to be very
27 successful in the UK, the IAPT model, and we adapted it for
28 the Australian context. We then trialled it in the real
29 world in three locations, we did an independent evaluation
30 in a business case and now our job is to work with primary
31 health networks, because this thing does work, to actually
32 get it scaled up.
33
34 New Access basically uses a new workforce that we call
35 coaches. These are people who do not have clinical
36 qualifications, they are people who are employed locally.
37 So, for example, in a rural area we employ farmers, we
38 employ people who are - you know, have been receptionists,
39 we employ a whole range of people who understand the local
40 environment and who can connect and communicate really well
41 with people. We put them through a rigorous training
42 program and then the service is provided free. You don't
43 need a referral from a medical practitioner. It can be
44 delivered face-to-face, it can be delivered online or it
45 can be delivered over the phone.
46
47 Q. Can I just ask you to explain, what is the service

1 that's delivered and how is it delivered?
2 A. Sure.
3
4 Q. So, if you are a consumer, how do you find the service
5 and what happens when you engage with it?
6 A. So, from the start, the marketing promotion is very
7 different. We do not talk about mental illness, we don't
8 talk about depression or anxiety. We talk about - we give
9 out messages like, are you struggling with your
10 relationship? Do you have money worries? Have you just
11 lost your job? Have you not had access to the kids for a
12 while? So that really draws people in because it doesn't
13 make them feel like they're different.
14
15 What then happens is, you can literally pick up the
16 phone and call one of the services and make an appointment
17 to see a coach. You come in, you have an initial
18 assessment with a coach, and that is a very safe, well
19 designed assessment. The coaches work with clinical
20 supervision, so everything a coach does is reviewed by a
21 clinician.
22
23 If you are assessed as being eligible, I guess, for
24 the program, and what I mean by that is, if someone is in
25 extreme or very severe psychological distress, they are
26 stepped up to a more appropriate service. If they are
27 experiencing mild to moderate anxiety or depression, they
28 then enter the program and they receive up to another five
29 free sessions with that coach.
30
31 The coach works with the person to identify what their
32 issues are, and then, in a very practical way, using
33 cognitive behavioural therapy techniques, works with that
34 person over those five sessions to teach them skills as to
35 how to deal with the issues going on in their lives.
36
37 A really important feature of New Access is that every
38 single point of contact between a person and their coach,
39 their psychological health and wellbeing is measured using
40 clinical scales, and that is recorded in real-time and
41 shown to the person and shared with the coach and shared
42 with the coach's supervisor, so that everybody can see how
43 that person is doing and then over time those measures are
44 recorded. So a person can actually see their improvement
45 and their recovery which is incredibly important.
46
47 During the trial period we saw recovery rates - so

1 that's someone with a "clinical caseness", we call it, of
2 psychological distress, so they are actually experiencing
3 quite often - these are not the worried well - they're
4 actually experiencing real symptoms of clinical depression
5 and anxiety; by the time they exit the program they are in
6 recovery. So, we're seeing recovery rates of around
7 70 per cent now consistently.
8
9 Q. So, where has this program been rolled out?
10 A. This is part of the challenge and one of the points
11 that I wanted to make today. This is a new model of care.
12 It is proven, it works, clinical outcomes are being
13 demonstrated. It's now in 17 sites around the country. In
14 Gippsland, for example, a service provider is being
15 commissioned right now. It's generally funded now by the
16 primary health networks. Beyond Blue licences the model to
17 those primary health networks for free, so there's 17 sites
18 now around the country.
19
20 But the problem that we're facing is that people don't
21 know about this service. Again, this is an example of, you
22 know, pilotitis, we've piloted this thing, we know it
23 works, we know it's cost-effective, we know it's developing
24 a new workforce, but GPs are not necessarily referring to
25 it and people themselves don't know it's available.
26
27 So we don't have the national infrastructure, in terms
28 of the workforce, the training, the data systems, but
29 importantly it's not valued, I don't think, as much as it
30 should be.
31
32 Q. Over what period of time has it been evaluated so far?
33 A. Well, we piloted it for, I think, two and a
34 half years, back in 2015, 16, 17, I believe from memory,
35 and then we did a rigorous clinical and economic evaluation
36 that was independent, and that evaluation looked at all the
37 data and the outcomes over that pilot period, and we
38 presented that evaluation in, I believe, 2017/18.
39
40 Q. Just one final question about that initiative. You've
41 talked about a new workforce. Is that a workforce that's
42 not the same as the peer workforce and it doesn't consist
43 of clinically trained practitioners?
44 A. That's correct.
45
46 Q. It's something in between?
47 A. That's correct. I mean, I think it's really important

1 to - it is not a peer workforce in the way that the peer
2 workforce is currently considered. Peer workers are people
3 with lived experience who model open recovery and ideally
4 work as part of a multidisciplinary team.
5
6 This coaching workforce is everybody, it can be
7 anyone. The kinds of skills and qualities we look for in
8 recruitment are great communication skills, life skills,
9 the ability to follow a program and not get too excited and
10 think you're better than you are and go off on a tangent.
11 But a lot of our coaches actually do have lived experience
12 as well.
13
14 Q. Can I now turn to the question of early intervention,
15 but perhaps before I do that, can I ask you about some
16 terminology. Can you distinguish, please, between primary
17 prevention, secondary prevention and tertiary prevention,
18 which I think are expressions you use in your statement?
19 A. Yes. And I'd like to acknowledge the work of
20 Everymind who developed a very good framework for
21 prevention called Prevention First.
22
23 So primary prevention are the things that prevent
24 onset or the development of mental health conditions,
25 they're the things that keep us well and thriving in our
26 communities.
27
28 Secondary prevention is the things that lower the
29 severity or the duration of an illness or a mental health
30 struggle, and generally through early intervention
31 techniques.
32
33 Then tertiary prevention are the things that reduce
34 the impact of mental ill-health, again ideally in the
35 community but also in more acute settings. Things that
36 help us to recover, things that prevent the relapse of a
37 mental health episode.
38
39 So, when we talk about early intervention and
40 prevention, we often talk about them early in life, early
41 in illness and early in episode, and that's a really
42 important concept because it's not just about keeping the
43 well, well; it's actually about equipping people to deal
44 effectively with signs and symptoms of distress or illness
45 when they develop, and that also goes to people who live
46 with severe and enduring mental illness.
47

1 Q. Can I take you to the question of early in life. What
2 do you mean by early and what types of conditions do you
3 mean to refer to when you talk about early in life?
4 A. It starts in the womb and it starts in the family
5 environments in which children are born into, and then it
6 works - you know, there's some fantastic studies that track
7 how children thrive or otherwise in those critical first
8 three years of life and whether they start to show the
9 emerging signs of behavioural or emotional difficulties,
10 and the correlation that then plays out in terms of their
11 risk of incarceration, their risk of living a life of
12 poverty, their risk of unemployment or likelihood of
13 unemployment. And we know from fantastic research,
14 including by the Murdoch Children's Research Institute here
15 in Melbourne, that the first thousand days of life are
16 really where we start to set down the factors and the
17 conditions that actually set us up for the rest of our
18 lives.
19
20 Q. What's significant about the first thousand days?
21 A. You'd have to ask someone much smarter than me, but
22 that's what the Murdoch Children's Research - but again,
23 it's about those formative years. From the moment we open
24 our eyes and scream, there are things, there are factors,
25 there are relationships that actually start to determine
26 how we think about our life and our identity and whether
27 that's, you know - of course babies maybe don't have that
28 level of consciousness. But whether or not - how parents
29 cope with not only settling of children, good sleep
30 patterns for children, healthy diets for children, the
31 warmth and affection that we show to children, those are
32 really formative.
33
34 And also the relationships between parents, often
35 including those who have their first baby; that changes
36 relationships, so how do we help parents through that often
37 quite turbulent time of having a child for the first time.
38
39 Q. Can I switch topics for a moment and ask you about
40 workplace. In your experience, on the basis of the work
41 you've been involved in, do workplaces have a role in
42 preventing mental illness and facilitating early
43 intervention in the development of mental illness?
44 A. They absolutely do. What we need to keep remembering
45 is that mental health issues start well before someone
46 enters the mental health system. They start in families,
47 they start in early childhood services, they start in

1 schools, they start in workplaces; that's where we really
2 need to, you know, continue to focus.
3
4 So workplaces: good work is really good for our mental
5 health. It not only pays the bills but it also gives us a
6 sense of meaning, a sense of purpose and a sense that we're
7 contributing something, and every day in workplaces around
8 Australia, there are people who are living and working
9 extremely effectively and productively with mental health
10 conditions as Dr Blanchard said yesterday.
11
12 There are some really positive things happening in
13 Victoria. The WorkWell program, $50 million program, is
14 really starting to roll out some really interesting
15 initiatives, giving grants to a range of workplace
16 settings, so Art Centre Melbourne for example, to help them
17 to design themselves the kind of workplace strategies that
18 are going to work for their employees and produce, not only
19 great places where people look forward to going to and
20 spending time, because goodness knows we spend enough time
21 at work these days, but also they're workplaces that are
22 highly productive and show a really positive return on
23 investment on very simple strategies that can be applied in
24 a workplace.
25
26 Q. And, are you aware of any research about the
27 contribution of workplaces to the development or the
28 worsening of mental health conditions where they don't have
29 those sorts of strategies in place?
30 A. Yes. We commissioned some research by PWC a few years
31 ago which found that the cost to business in Australia
32 through absenteeism, presenteeism and workers' compensation
33 claims, with worker's compensation claim expenses being, I
34 think, less than 1 per cent of that total cost, is
35 $11 billion in lost productivity. So, that's a big number.
36
37 We also know that, through strategies that build a
38 mentally healthy workplace environment, those same
39 businesses can see a return on average of $2.30 for every
40 $1 that they invest.
41
42 Q. Can I take you back to the number you mentioned a
43 moment ago: was that specifically related to absenteeism
44 and the like in connection with mental health conditions?
45 A. Yes, so untreated depression and anxiety mainly. I'd
46 also like to make the point that we are doing much better
47 in terms of anxiety and depression and I think that

1 evidence came out yesterday, that where we really need
2 business and industry and workplaces more generally to step
3 up and get with the program is creating opportunities and
4 reducing discrimination against people who live with severe
5 and complex mental illness; because again, these are people
6 who are incredibly contributing to our workplaces.
7
8 Q. Can I just take you back to the statement you made a
9 moment ago about "doing much better in the workplace in
10 relation to depression and anxiety. What are you
11 comparing? When we're doing better, compared with what?
12 A. Look, I guess the best way I can describe that is in
13 my role. So, I've been at Beyond Blue for five years.
14 When I started at Beyond Blue, we had been working in
15 workplace mental health for a number of years but we just
16 launched a national initiative called Heads Up which gives
17 every business of any size access to a whole range of
18 tools, evidence strategies, with support from three people
19 in my team to actually implement individualised workplace
20 strategies for them.
21
22 When I first started at Beyond Blue, I literally had
23 to smash on doors to be allowed in to talk to CEOs and to
24 talk to boards and to talk to decision-makers within
25 business and industry. Now I have to beat them off with a
26 stick. You know, every week I'm speaking to these kinds of
27 groups, at least twice a week. We are inundated with
28 requests from business and industry for support, for
29 guidance about how they can develop their own strategies.
30
31 There's a burgeoning industry of conferences about
32 workplace mental health, so I think those are indicators
33 that we have, I guess, in a relatively short space of time,
34 I think we're starting to win the argument that the
35 responsibilities of employers are not just to provide a
36 physically safe workplace but also a psychologically safe
37 workplace, and business leaders are starting to understand
38 that that's not just the right thing to do from a human
39 perspective, it actually makes good business sense too; it
40 sets them up as an employer of choice.
41
42 Because, through our own studies we are as workers
43 looking for different things in our employers. We're not
44 just looking for pay packets. The second most important
45 factor that influences our choice as to who we want to work
46 for these days is actually the perception of whether or not
47 the workplace is mentally healthy.

1
2 Q. Can I ask you where that comes from?
3 A. That's again our own Beyond Blue commissioned
4 research. So, we've done a lot of qualitative research
5 reaching out to both leaders and decision-makers in
6 business and industry, but also employees themselves. So,
7 that was a study we did, I think from memory, in about
8 2016.
9
10 Q. And, what was the population that was studied in that
11 particular --
12 A. It was several thousand, yeah.
13
14 Q. Can you just repeat that, did you say the second most
15 important factor is --
16 A. That's right.
17
18 Q. -- is what?
19 A. So, when we make a decision about who we want to work
20 for, the number one consideration for most of us is
21 remuneration and conditions. The second most important
22 factor in our decision-making - and this came out of our
23 study - is whether we believe that that workplace takes our
24 mental health seriously.
25
26 So, this is a really stark differentiator for
27 employers who actually want to show leadership, because not
28 only is it going to attract the best and brightest, it's
29 going to keep them too; and it's also going to reduce the
30 turnover of staff, it's going to enable those people in
31 those workplaces and in those jobs to be confident in
32 disclosing and speaking out when they are starting to
33 struggle or where they live with a mental health condition
34 and need some reasonable adjustments in order to maintain
35 their mental health or to recover from an episode of mental
36 illness. It also means that, you know, it has massive
37 productivity and participation flow-on effects.
38
39 Q. Do you know who the population was that participated
40 in that study?
41 A. Again from memory, I mean, I can confirm this with the
42 Commission after my evidence, it was pretty evenly split
43 between those in the workforce and those in leadership
44 positions in the workforce.
45
46 Q. I see.
47 A. We also found quite a stark difference between those

1 two groups where, you know, people like me who think we
2 know everything thought we were doing a pretty good job,
3 but our employees actually agreed to disagree.
4
5 The other really important finding in that research
6 was that, when leaders step up and lead on this stuff and
7 do that authentically and in a sustained way, not just a
8 tick the box exercise, that has a massive impact on the
9 perceptions of their staff.
10
11 So, where a staff recognises or believes that their
12 CEO is genuine about this stuff, they are four times less
13 likely to take time off work for a depressive illness than
14 if they don't believe their CEO.
15
16 Q. We might ask you to make that study available to the
17 Commission, if you would.
18 A. Of course.
19
20 Q. Just before we leave workplace, can I ask you about
21 the disparity you mentioned before about progress in
22 relation to depression and anxiety and more complex and
23 severe mental health issues.
24 A. I think it goes back to some of the issues that were
25 talked about yesterday. Depression and anxiety are by far
26 the most prevalent mental health conditions in Australia:
27 about 3 million of us live with either one or both of those
28 conditions.
29
30 We tend to still as a society believe that people who
31 live with schizophrenia, bipolar disorder, are somehow
32 different to us, and I think we've still got a long way to
33 go to break down that stigma and discrimination just at a
34 population level.
35
36 When you take that into the workplace it becomes even
37 more acute because somehow, if on day 29 of a month - you
38 know, just say I live with schizophrenia - and then all of
39 a sudden on day 29 I disclose that; on day 30, somehow I'm
40 seen differently. I might have been doing a fantastic job,
41 I might be really valued and respected by my teammates and
42 the people I report to, but somehow after I've disclosed
43 that I might live with schizophrenia, now I'm unreliable,
44 I'm flakey, you know, I'm potentially dangerous. So, we
45 have a long way to go.
46
47 Q. Has Beyond Blue commissioned research into that

1 question?
2 A. No, we haven't, we haven't. Our mandate is to really
3 focus on depression and anxiety and suicide prevention, but
4 we are cheering on our colleagues like SANE who are doing
5 fantastic work to try and measure this.
6
7 Q. Alright, thank you. Can I ask you just one question
8 about Beyond Blue's work in connection with suicide
9 prevention?
10 A. Yes.
11
12 Q. This is a topic which we'll be considering in greater
13 detail later on in the Commission's work. You've said in
14 your statement that:
15
16 "Beyond Blue is advocating with many others
17 for a universal system for suicide
18 prevention so that all people at any time
19 at any place can get proper support they
20 need when they're feeling suicidal. Such a
21 system should take a social determinants
22 approach, recognising that suicidality is
23 influenced by communities, relationships
24 and a range of socio-economic factors."
25
26 There's a number of things rolled up in that. Can I
27 ask you, specifically in connection with what you've called
28 "a universal system for suicide prevention", what do you
29 mean by "a social determinants approach"?
30 A. Again, it goes back to not just thinking about suicide
31 prevention in a mental illness paradigm. There is a
32 relationship between mental health issues and illnesses and
33 suicide risk and suicidal behaviour: absolutely
34 indisputable, but it's not linear and it's more complex
35 than that.
36
37 So we know, for example, that people who think about
38 suicide or attempt suicide, or indeed die by suicide, many
39 do live with mental health conditions; but some don't, and
40 it can be those tipping factors in life that actually cause
41 suicidal distress.
42
43 So, for example, homelessness, losing your job, living
44 in extreme poverty, or you're just not able to put food on
45 the table or pay the rent; relationship breakdowns, these
46 are the life stressors that can massively contribute to
47 suicidal behaviour and suicide attempts.

1
2 Q. And, when you say "universal system", what do you have
3 in mind specifically?
4 A. So, there's a number of components to that and I think
5 the starting point is at a population health level.
6 Similar to what we have done with, you know, talking about
7 depression, for example, we need to change the conversation
8 about suicide prevention, and we need to do that with
9 confidence. Because we know that - and again I will refer
10 to a study commissioned by Beyond Blue and released in 2016
11 that was conducted by Melbourne University and Whereto
12 Research, that surveyed in a mixed method around 3,000
13 everyday Australians, and that included a few hundred
14 people who had had recent experience of suicide or suicidal
15 behaviour; so they'd either attempted, they'd been
16 bereaved, self-harmed in the previous 12 months.
17
18 What we found from the general community is a level of
19 concern that was really, really strong about suicide, so
20 the community's deeply concerned, but feeling quite
21 impotent in many ways about their role in playing a role in
22 suicide prevention.
23
24 They want to, that's what they told us: we want to do
25 the right thing, we want to be part of the solution, but
26 there's still some real myths that exist which are
27 preventing people from playing an active role.
28
29 So, for example, 50 per cent of people who
30 participated in that study believe that you need to be a
31 health professional to have a conversation with someone
32 about suicide, someone that you might be concerned about.
33 That is not true.
34
35 About 30 per cent believe that, if you talked directly
36 to someone about you being concerned about them being at
37 risk of suicide, you would make things worse or you would
38 somehow put the idea in their head. That is not true.
39
40 And importantly, the people with lived experience of
41 suicide and suicidality told us, in no uncertain terms,
42 they want people to be talking to them about this, but they
43 don't want - they want people to ask the questions and then
44 they want them to shut up and listen with empathy, but
45 knowing that someone cares is really important to help
46 someone through a suicidal crisis.
47

1 So armed with this research evidence we have been
2 collaborating with six other national mental health and
3 suicide prevention organisations to create a - I guess a
4 campaign called #YouCanTalk which uses social media as its
5 channel. Really what we're saying to the community is you
6 can talk about suicide, you can talk safely about suicide,
7 you don't need to be a professional, these are the
8 questions you can ask, and this is what you do when you get
9 a response. This is what to say, this is helpful, this is
10 unhelpful things to say.
11
12 So, we actually are helping people to grow in
13 confidence and to know what to do, but importantly what to
14 say; that's the level of literacy we're dealing with, so
15 that is one thing that we need to do, we need to encourage
16 those conversations because quite often that can be a
17 turning point for people.
18
19 We also need a system that supports people in
20 pre-suicidal distress. What we know from lived experience
21 but also research is that, quite often there is an
22 escalation path to when people reach suicidal crisis, and
23 there are flags that actually are in existence. So, how do
24 we actually support people early, to teach them about the
25 signs and symptoms?
26
27 But also create, for example, low intensity
28 interventions, these kind of New Access coaching type
29 things, which again help people to, in very practical ways,
30 to deal with their suicidal - potential suicidal
31 behaviours.
32
33 How do we keep people safe by using safety plans? And
34 those can be done on your smartphone now with Beyond Now
35 safety plan app, which is a personalised plan that you can
36 make and share with your health professions and your
37 friends and your family.
38
39 Q. How widely spread is that and has it been actively
40 rolled out?
41 A. Yes. We launched that, again, I think about three
42 years ago: about 25,500 suicide plans have been made by
43 Australians.
44
45 Q. And what is a suicide plan?
46 A. So, it's a very simple step-by-step process that you
47 use - it's an app that you download for free and it

1 basically takes you through about four or five steps which
2 firstly identify what your suicidal triggers are. Then it
3 asks you questions about, and what are the things that help
4 you to - remind you to keep living? Who are the people
5 that you trust that you can call on and you can empower to
6 be part of your solution to keep you safe? And
7 importantly, what are the crisis numbers that are
8 hard-wired into this app for you to deal with?
9
10 So, really it's just a process that you can work
11 through step-by-step when you are in suicidal crisis that
12 hopefully draw you back into living. Because we know that,
13 for many people, these feelings do pass.
14
15 Q. How have you evaluated how that's working?
16 A. Well, predominantly through user feedback. It was
17 built on very, very solid evidence, including the support
18 of Barbara Stanley, Professor Barbara Stanley from the US
19 who's been working in evidence-based suicide planning for
20 Veterans, in particular in Defence personnel in the states,
21 and those are often paper-based approaches. So, we've
22 taken all of those evidence and those pathways and put them
23 into an app.
24
25 The other thing about the app, we've just enhanced it
26 so that you can actually put photos in, so you can actually
27 save a photo of someone that - you know, maybe it's your
28 son or your daughter. You can put music in, maybe it's a
29 soundtrack that you listen to that actually helps you to
30 kind of either distract you or calms you down, so very,
31 very practical things.
32
33 We've done a bunch of qualitative surveying of users
34 to help us to do that latest enhancement, and obviously we
35 looked at the activity numbers, so the numbers of
36 downloads, the numbers of plans actually made, and we also
37 encourage people to share those with their health
38 professionals and family and support networks.
39
40 Q. And how long did you say that's been going for?
41 A. I believe we launched it in 2016/17, around that time.
42
43 Q. What's the thinking about the utility of having it
44 available on an app?
45 A. Well, you can be pretending to be looking at dog -
46 pictures of your dog, you can be at the bus stop, and quite
47 often these are places where people are facing suicidal

1 crisis. So, it's a very discreet way of accessing
2 something and it's there. I mean, many of us are so, you
3 know, linked to our smartphones these days, they are in our
4 back pockets constantly, they are at the side of our beds
5 when we go to sleep at night, so it's there and it's in a
6 form that we're very familiar with and that we can easily
7 access, and again, in a discreet way.
8
9 Q. Thank you. We've asked you a number of questions
10 about what needs to be better done to address the
11 determinants of mental illness and assist in early
12 intervention and prevention. One of the things you've said
13 in your statement is that:
14
15 "A consistent theme in the analysis in
16 which Beyond Blue's been involved is that a
17 significant challenge is collecting and
18 linking the right data across jurisdictions
19 regularly and in as real-time as possible,
20 analysing patterns and trends and linking
21 service funding to levels of demands and
22 outcomes."
23
24 What, on the basis of the information available to
25 you, are the most significant gaps in data gathering
26 insofar as that relates to Victorian health services?
27 A. Sure. Could you indulge me and allow me to just add
28 one more thing to the universal suicide prevention system?
29
30 Q. Yes, of course.
31 A. I think the other really strong evidence is for new
32 models that are based in the community to assist people who
33 are in suicidal distress or crisis. At the moment all
34 roads lead to emergency departments and there are a number
35 of emerging and established models - what we call safe
36 spaces in the community - there's a great example at
37 St Vincent's in Melbourne, the Safe Haven Café; there's a
38 great example in Aldershot in the UK, and there's some
39 fantastic work being done by the Red Cross and Wesley
40 Mission in Brisbane. These are places and spaces in the
41 community that give people alternatives to going to an
42 emergency department; they give alternatives to paramedics
43 for people in suicidal crisis than going to an emergency
44 department.
45
46 I need to clarify, if people are facing
47 life-threatening injuries, then of course they need to be

1 transported to an emergency department. But what we know
2 repeatedly from studies, but also the voices of people who
3 live with suicidal crisis regularly, is that they don't
4 want to go to emergency departments. These are places
5 where there is hard surfaces, there's bright lights,
6 there's lots of noise, and these are factors that often
7 escalate their psychological distress, and where the
8 incredibly busy professionals quite often don't have the
9 time that's needed to sit with empathy with someone and
10 actually work with them over an extended period.
11
12 So, if we can create alternative spaces in the
13 community that have great governance, that are linked to
14 clinical services when they need to, but that are peer-led,
15 we know that these services are growing in their evidence
16 and that they have the potential to significantly reduce
17 costs to the health system through re-admissions,
18 representations, the cycling of people in and out and
19 presentations to emergency departments.
20
21 Q. While we're on that subject, Beyond Blue's recently
22 done some work with presentations to ambulance services
23 with men?
24 A. Yes.
25
26 Q. Did that work reinforce comments you've just made?
27 A. Look, it absolutely did. It showed - so six states
28 and territories shared their ambulance data with Turning
29 Point, our partners in the research study, including
30 Victoria, and they tracked over several years the number of
31 call-outs and presentations and transportations of
32 ambulance services for men suffering acute mental health
33 crises and also suicidal crisis.
34
35 We know around Australia 82 ambulances are called out
36 every day, to men only, in suicidal crisis. That's about
37 three times the level of data that are collected by
38 emergency departments in hospitals. So, you know, the
39 official data is really just showing the tip of the
40 iceberg.
41
42 We know from that study that only about 14 per cent of
43 paramedics felt that they had had sufficient training in
44 how to deal with this and we need to address that.
45
46 It also showed that about 42 per cent of those men had
47 called an ambulance at least one other time in a 12-month

1 period, and 7 per cent - I think 7 per cent - of men in
2 that group had called an ambulance ten or more times.
3
4 So, there's the constant cycling and re-presentation
5 to emergency departments and then just the letting go of
6 those people into the circumstances that often added to
7 their suicidal distress.
8
9 Q. Thank you. I asked you a few moments ago about gaps
10 in data collection.
11 A. Yes.
12
13 Q. Is there a particular point you wanted to make about
14 missing data?
15 A. Look, I think the main point is that, we have these
16 big investments in big parts of a system that don't talk to
17 each other, and that's, you know, cross-jurisdictional but
18 also intra-jurisdictional, and the data linkage is
19 incredibly important, I think, so that we can start to
20 track, you know, the correlation and the outcomes around
21 the link between secure housing, for example, and access to
22 mental health services.
23
24 But importantly, we're measuring the wrong things,
25 we're collecting the wrong things; we're collecting lots of
26 activity data so we're collecting - you know, this is
27 important, the rates of re-admission and the lengths of
28 stay in hospital for example for mental health reasons.
29
30 But that actually doesn't tell us - it's the outcomes
31 for those people who have been through that system, and
32 indeed, whether or not someone is alive or dead 12 months
33 later, to put it really frankly; I mean, those are the
34 kinds of things that we actually don't measure because we
35 have the inability to track people in real-time and to know
36 whether or not an intervention actually worked: whether or
37 not we put the social and the health supports around a
38 person to enable them to cope and to recover and to live
39 well and thrive in their community or not.
40
41 Q. Can I just ask you what you mean by "the ability to
42 track people in real-time"?
43 A. So, for example, we have no idea - so our national
44 suicide data, for example, is - by the time we get it, it's
45 two or three years old. There are emerging suicide
46 registers which do collect suicide data in more real-time,
47 and that's a great thing.

1
2 But again, you know, having surveillance systems that
3 are far more real-time, that are more localised, that
4 enable local services, communities, first responders,
5 health services, mental health services, schools, to be
6 identifying emerging clusters of suicide, for example, and
7 then to wrap-around supports for a school community, for
8 example, where there might be a spate.
9
10 Q. Thank you. Can I finally ask you this: you have said
11 in your statement that, in response to our question, "What
12 are the most significant challenges facing the mental
13 health system?":
14
15 "The first challenge is a lack of long-term
16 inter and intra government design and
17 planning and lack of clarity of roles and
18 responsibilities. This is exacerbated in
19 times of fiscal constraint and by electoral
20 cycles."
21
22 Can you elaborate on that?
23 A. The one point I would really like to urge or plead the
24 Commissioners to think about is, we have an unprecedented
25 opportunity with this amazing Commission in Victoria to be
26 working with and alongside a Productivity Commission that's
27 happening at a national level; that is looking also at the
28 whole system.
29
30 Part of the challenge - and, you know, I speak from
31 experience as a recovering public servant, is that, you
32 know, we very often design systems around us and we design
33 systems that again categorise parts of people's lives, and
34 that are around politics and policy decisions that are made
35 around fiscal circumstances.
36
37 Can I plead that we use this opportunity where you
38 actually work with your colleagues at the
39 Productivity Commission to fix all parts of the system, and
40 I think it would be an extraordinary thing if that were to
41 happen and there be some national policy decisions taken
42 for genuine systematic change that then can be implemented
43 in a Victorian sense as well.
44
45 So, how can the Commonwealth and the Victorian
46 governments be working together to show that we can do
47 this, because we know what we need to do. It's actually

1 just - it is complex, it is painstaking, but we can do it
2 if I think we put aside politics, we put aside short-term
3 funding cycles, we put aside electoral cycles, and we say,
4 multiple reviews have told us to do these things.
5
6 It is about structural change, it's about new models
7 of care, it's about new models of thinking. Let's come
8 together as governments and let's plan at least a decade
9 worth of plans. Let's actually put accountabilities in
10 those plans. Let's actually decide the sequencing of the
11 things that we're going to do first, knowing that that's
12 not going to make everybody really happy, but we've got the
13 long-term plan to get there.
14
15 Measure success, hold your - set targets, be
16 accountable, but importantly let's let this thing survive
17 the slings and arrows of electoral cycles, because people
18 and families have been asking for this for a long time and
19 I think it's incumbent on all of us to be part of that
20 long-term planning and solution.
21
22 MS NICHOLS: Chair, do the Commissioners have any
23 questions?
24
25 CHAIR: No, thank you very much.
26
27 MS NICHOLS: May Ms Harman be excused, please?
28
29 CHAIR: Please be excused, and thank you very much for
30 your contribution this morning.
31
32 <**THE WITNESS WITHDREW**
33
34 MS NICHOLS: The next witness is Professor David Forbes.
35 I just wonder whether we might have a short break; is that
36 convenient?
37
38 CHAIR: Yes.
39
40 **SHORT ADJOURNMENT**
41
42 MS COGHLAN: Commissioners, the next witness is Professor
43 David Forbes, and I call him now.
44
45 <**DAVID FORBES, sworn and examined: [11.30am]**
46
47 **MS COGHLAN:** Professor, I'll just ask that you make

1 yourself comfortable there and get in a position so that
2 you can be heard in the microphone.
3 A. Okay.
4
5 Q. Thank you. Professor, you have made a statement with
6 the assistance of the Commission, have you?
7 A. I have.
8
9 Q. I tender that statement. [WIT.0001.0012.0001] You,
10 professor, are a clinical psychologist?
11 A. That's correct.
12
13 Q. And you're the director of Phoenix Australia Centre?
14 A. That's correct.
15
16 Q. The official name is Phoenix Australia Centre for
17 Posttraumatic Mental Health?
18 A. That's correct.
19
20 Q. And we'll just refer to it as Phoenix, but that's the
21 official name. You've been an employee of Phoenix since
22 1999?
23 A. That's correct.
24
25 Q. Appointed as deputy director at that time?
26 A. Correct.
27
28 Q. And director in 2011?
29 A. Correct.
30
31 Q. You are a professor with the Department of Psychiatry
32 at the University of Melbourne?
33 A. That's correct.
34
35 Q. And you have a strong background in research, having
36 authored over 160 publications?
37 A. That's correct.
38
39 Q. Can you tell the Commission, please, about your
40 expertise in the field of psychological trauma?
41 A. So, my experience and expertise in the field of
42 psychological trauma, as a clinician, as a researcher and
43 as a practitioner working in the field. Speciality in the
44 assessment and treatment of military and veteran mental
45 health, first responder mental health, but then more
46 broadly also with community mental health and trauma,
47 assault and sexual assault survivors, domestic violence

1 survivors, natural and man-made disaster survivors; that's
2 examples.
3
4 Q. Just in relation to Phoenix, it's a not-for-profit
5 organisation?
6 A. That's correct.
7
8 Q. And it's affiliated with the University of Melbourne?
9 A. Correct.
10
11 Q. What's its mission?
12 A. The mission of Phoenix Australia is to improve
13 outcomes for those who are affected by trauma across the
14 Australian community, working with individuals, working
15 with organisations, and working with communities more
16 general in terms of supporting their recovery in the
17 aftermath of trauma exposure.
18
19 Q. Phoenix has three distinct arms in terms of the work
20 that it does?
21 A. Correct.
22
23 Q. Can you please just detail what they are?
24 A. So, there are three arms to Phoenix: they're distinct
25 but we would see them as interacting and relating to each
26 other.
27
28 The first arm is around research and evaluation, and
29 that is really trying to better understand the nature of
30 the mental health effects of trauma: what's the
31 phenomenology, what's the experience of trauma, how can we
32 better understand that, as well as research pushing the
33 dial forward in terms of the improvement of interventions
34 and treatments for trauma.
35
36 Q. And that's also considering new interventions?
37 A. That's considering new interventions, it's testing
38 existing interventions with different trauma exposed people
39 with PTSD, as well as testing new intervention, from
40 prevention, through early intervention, through the
41 treatment of complex mental health problems following
42 trauma.
43
44 The second line is what we call our policy and service
45 development area and that's really working with developing
46 national benchmarks for the treatment of posttraumatic
47 stress disorder and other trauma related disorders. So,

1 there we developed the National Guidelines, the Australian
2 National Guidelines for the Treatment of Posttraumatic
3 Stress Disorder through the NHMRC with the engagement of
4 the health professional colleges, and that becomes a
5 benchmark that we work with organisations whose members are
6 affected by trauma in the line of the work they do: that's
7 military veterans, those who work in national security,
8 first responders around the country, those exposed to
9 occupational violence for example, as well as benchmarks
10 for how to work with communities in the delivery of what
11 best practice treatment looks like.
12
13 The third arm of Phoenix is a workforce development or
14 a skilled development arm, and that really takes what the
15 evidence is telling us, it's telling us what the best
16 practice is telling us, and then implementing that with
17 organisations and with service providers in training and
18 teaching what best practice treatment skills look like and
19 then the delivery of those best practice treatment skills;
20 that's both at the provider end, providing clinical
21 treatment, and also to organisations about what best
22 practice is for caring for one's own members who are
23 affected.
24
25 Q. And that can be as simple as training managers and
26 supervisors?
27 A. Correct. So, within the organisations, we'll train
28 those who provide clinical care in best practice
29 treatments, but we'll also train managers and supervisors
30 right up through the organisations in how best they need to
31 provide support and guidance to their own members who are
32 affected within the organisational framework.
33
34 Q. At present, does that focus on, as you've said,
35 organisations where their employees might face trauma?
36 A. So, predominantly it has. So, those kind of
37 organisations are, for example, Defence, those in national
38 security, so a whole range of organisations working
39 nationally and under the umbrella of Home Affairs:
40 Australian Federal Police for example, border protection,
41 customs border protection, and also at first responder
42 levels around the country: police, ambulance, fire
43 brigades, and all manner of organisations who are exposed
44 to trauma in the line of work that they do.
45
46 Q. Can I ask you a question about what psychological
47 trauma is, and will you address in your answer the clinical

1 definition as well as perhaps more what people might
2 understand in their day-to-day lives as to what
3 psychological trauma might be?
4 A. Sure. When we're talking lay language around
5 something being traumatic, we usually mean an event that's
6 caused us an enormous amount of distress or an overwhelming
7 amount of distress.
8
9 In the mental health field specifically, trauma has
10 quite a specific meaning or definition. And when we're
11 talking about trauma within the mental health field, we're
12 talking about more specifically an event that's threatened
13 a person's life or their physical integrity that they
14 experienced or witnessed, or a part of via some other
15 means, for example electronic means.
16
17 So it's a little bit different to the word we use for
18 trauma in the general community, which is about a very high
19 emotional impact event. In the mental health space we are
20 talking about fairly specific kinds of events when we're
21 talking about traumatic, potentially traumatic events.
22
23 Q. Just to break that down: in the field it does have a
24 particular definition which means that a person must have
25 been through an event that either threatened their life or
26 threatened their physical or psychological integrity?
27 A. Or witnessed, or witnessed those events, yeah.
28
29 Q. Okay. So, can I ask you about that in terms of, can
30 you explain more about how a witness might be impacted by
31 that?
32 A. So, certainly when you're exposed to events it still
33 has the similar psychological impact. So, for example,
34 commonly reported it would be, for example for ambulance
35 members coming across the horrific scene of a car accident,
36 or in the aftermath of combat or conflict, actually being
37 exposed to the aftermath of horrendous death and
38 destruction following a humanitarian disaster or a natural
39 disaster, community members or emergency services or first
40 responders being exposed to the aftermath. So, one is
41 being in it; the other is also being exposed to seeing
42 horror and suffering occurring or having occurred to others
43 has a significant psychological impact also.
44
45 Q. And so, is the situation where it happens to someone,
46 that's called indirect - sorry, that's called direct?
47 A. Yeah, so where it's direct or where you're part of the

1 experience where you're witnessing it.
2
3 When we talk about indirect, we're talking about where
4 you're part of the experience but you're not physically
5 present. So, for example, for people who work on call
6 centres for example, 000 call centres, they're not
7 physically present at the event which can be a major life
8 or death experience that's going on at the time, but
9 they're part of it by virtue of the fact that they're
10 actually transmitting information in real-time.
11
12 So, really important is that, you don't have to be
13 physically present where you're to be part of that event
14 where you're participating by electronic means, for
15 example.
16
17 Q. And that then, you might be - there might be indirect
18 trauma in those circumstances?
19 A. Correct.
20
21 Q. What about a situation then of someone watching an
22 upsetting event on the news: would that lead to indirect
23 trauma in this definitional sense?
24 A. So again here we're distinguishing between - so, the
25 definition of trauma and what might be extremely
26 emotionally distressing.
27
28 So, for example, watching 911 happen in real-time is
29 extremely distressing, particularly not knowing what was
30 going to happen next as well, but it wouldn't technically
31 meet the criteria for traumatic exposure in relating to the
32 specific kinds of mental health problems that might emerge
33 from that.
34
35 Again, it's a really important distinction, which is
36 what it's not doing is diminishing the emotional impact of
37 things that occur outside of that definition, but it's
38 saying that they tend to have a slightly different clinical
39 presentation from those that might meet the more strict
40 trauma definition, is the clinical presentations of those
41 look different to other kinds of emotionally demanding or
42 impactful events outside of the trauma space.
43
44 Q. Okay, so just in terms of considering psychological
45 trauma in the way that you've described it, can you just
46 give an example of the type of events that might be
47 traumatic in that definitional sense?

1 A. Sure. So, common is physical and sexual assault,
2 surviving disaster, natural disasters, man-made disasters,
3 domestic violence, childhood neglect and abuse; more
4 broadly, issues in relation to combat or exposure to horror
5 or death occurring for others, all those kinds of events
6 are potentially traumatic events.
7
8 Importantly, evidence tells us that about 70 per cent
9 of Australians have experienced a potentially traumatic
10 event at some stage of their lives, so it's very common to
11 actually experience a potentially traumatically event at
12 some point in your life. And that data is consistent with
13 what we see internationally as well.
14
15 Q. Just before we get into further discussion about the
16 potentially traumatic event, can I just take you back to
17 the kind of things that you were describing that may be
18 traumatic for people. So, for example, if there's some
19 kind of sexual or physical abuse, just taking that as an
20 example, you would call that a traumatic stressor?
21 A. Yes, I would.
22
23 Q. Is there a difference between things that might be a
24 primary stressor and then a secondary stressor?
25 A. Sure. So probably a clear example of primary and
26 secondary stressors, take for example a natural disaster:
27 bushfire, floods, so we'd see that as a primary stressor,
28 primary traumatic stressor. Then there's a whole series of
29 what we'd call secondary stressors that occur afterwards,
30 which is your loss of income as a result of that event,
31 your loss of your home as a result of that event,
32 navigating your financial future, navigating with insurance
33 companies to be able to rebuild and reconstruct your home,
34 the loss of your social network. All of those things are
35 the secondary stressors that can flow on from the primary.
36
37 Really important is that these secondary stressors
38 further increase the risk of developing mental health
39 problems in the aftermath of these events.
40
41 Q. Are there also other types of the secondary stressors
42 in terms of the things that might flow on from an event?
43 A. Sure. So, the other kinds of secondary stressors are
44 the way that people respond to you afterwards also. So,
45 after an event, for example, where we're talking about
46 sexual or physical abuse, the degree to which others -
47 you're blamed for that event or feel like you're ostracised

1 in talking about that event; engaging in a legal process
2 whereby you feel like it's an adversarial process and
3 you're made to have to justify your experiences, all those
4 are the kinds of what we might call interpersonal or social
5 secondary stressors that might occur afterwards that again
6 ramp up the risk of developing a more serious mental health
7 response to the primary event.
8
9 Q. Can you just please describe what complex traumatic
10 trauma is?
11 A. So, we use the word complex trauma when we're talking
12 about traumatic events that are repeated, so where they've
13 occurred a number of times, and also where they have gone
14 over a course of a number of years, and also where they are
15 interpersonal in nature; so ongoing physical or sexual
16 abuse, domestic violence, kidnapping, incarceration,
17 interrogation, those kind of events are the kind of events
18 that lead to - kind of events we tend to classify as
19 complex trauma.
20
21 Last year there's a new diagnosis came out in the
22 international classification of diseases which is actually
23 complex PTSD as a new diagnosis recognising different kinds
24 of trauma exposures that fit the criteria of complex
25 exposure.
26
27 Q. What about the concept of developmental trauma in
28 children, can you just describe that, please?
29 A. So, in children, obviously where they're experiencing
30 these kinds of events we describe this as developmental
31 trauma where the child's been exposed to kind of ongoing
32 abuse, neglect, and the abuse being physical or sexual
33 abuse, so particularly at critical stages of life this can
34 have a highly significant impact on mental health recovery
35 going forward.
36
37 So, when we think about complex trauma and we think
38 about complex PTSD, ongoing childhood abuse, physical and
39 sexual and neglect, are core features in what we would
40 routinely be first off thinking about in relation to those
41 difficulties.
42
43 Q. We heard from Georgina Harman this morning about
44 psychological trauma being a determinant of mental illness;
45 that may be evidence that you heard. What are common
46 disorders that can flow from traumatic events?
47 A. So, the most common mental health problems that would

1 flow on from traumatic events are posttraumatic stress
2 disorder and depression; we also see other anxiety
3 disorders, like panic disorder, agoraphobia, substance use
4 disorders, and in the more - it also is a risk factor for
5 more severe mental illness, like schizophrenia, bipolar
6 disorder and severe - like, significant personality factors
7 such as borderline personality disorder.
8
9 But it's probably important to say that depression and
10 posttraumatic stress disorder are the most common, and in
11 fact posttraumatic stress disorder is the second most
12 common mental health disorder in Australia. So, we have a
13 current prevalence rate of about 4.4 per cent, which means
14 over a million Australians in any given year experience
15 posttraumatic stress disorder.
16
17 Q. Earlier on you mentioned the phrase "potentially
18 traumatic event", I want to ask some questions about that
19 now. It's the case, isn't it, that not everybody will go
20 on to develop some kind of disorder or illness following a
21 potentially traumatic event?
22 A. Yeah, that's correct.
23
24 Q. And so, what are the factors that might contribute to
25 whether someone does?
26 A. Okay. And, hence we call these events - (phone
27 rings).
28
29 Q. Glad it's you.
30 A. My apologies, I'd sworn that was off. My apologies,
31 Commissioners. When we think about potentially - we call
32 the term potentially traumatic events because, for exactly
33 the reason that you've mentioned, but the reality is that
34 not everybody develops a mental health disorder or problem
35 in the aftermath of exposure.
36
37 There are three levels of risk factors we think about:
38 we think about who likely develops and who doesn't. Some
39 of those are pre-event risk factors, some of them relate to
40 the event itself, and some of them relate to what happens
41 afterwards.
42
43 When it comes to pre-event risk factors, they are kind
44 of pre-existing biological vulnerabilities, they have a
45 pre-existing history of mental health problems, they have a
46 previous history of exposure to trauma.
47

1 When it comes to the event related factors, these
2 become more complex. So, the event related factors fall
3 into a range of camps. So, one is the degree to which your
4 life is threatened, the degree to which you think you're
5 going to die is a significant factor in terms of increasing
6 risk.
7
8 The degree of physical intrusion into your physical
9 integrity, so sexual assault increases the level of risk.
10 The degree to which - how long it goes on for, so duration
11 of the event increases risk; how many times things happen
12 increase risk. So, those things increase the likelihood of
13 developing problems.
14
15 The other part are issues that we call predictability
16 and controllability, which is to what degree did you feel
17 like you had some control at the time and to what degree do
18 you feel like it's predictable. A kind of a routine or
19 simple example would be, being assaulted for example
20 walking down the street at night in a street that you knew
21 to be the most dangerous street in Victoria, compared to
22 being assaulted in a very similar way watching television
23 in your back room at home and someone comes through the
24 back window.
25
26 So, those events, the assault may be the same, even in
27 the level of severity, but the implications in terms of the
28 impact on you, what your belief is about safety in the
29 world and predictability of the world and your capacity to
30 control events around you change dramatically.
31
32 The other part of events that are important is the
33 reaction at the time, and the two reactions at the time
34 that tend to heighten risk are: naturally enough when we're
35 threatened our body's alarm goes off and we get what we
36 call hyperarousal, which is extremely keyed-up. How
37 keyed-up we get and how long that goes on for, the degree
38 to which it settles or doesn't settle is a really important
39 predictor.
40
41 Or the opposite, whereby we short-circuit and we
42 switch off emotionally and feel nothing, where we feel
43 distanced or separated from the event and feel like we're
44 watching the event from outside where we feel like we'll
45 shut that off or shut that down, and that's what we call
46 disassociation, so those kinds of reactions also give us a
47 clue as to risk.

1
2 The last group of factors is what happens after the
3 event, and the two critical elements there are the degree
4 to which there is an ongoing experience of stress. So, for
5 example, coming back to the example I gave you before about
6 primary stressors and secondary stressors: in the aftermath
7 of a natural disaster when we're having difficulty, where
8 we've lost our income and we're dealing with insurance
9 companies and having trouble rebuilding our home, where
10 you're having difficulties regaining your employment, those
11 kind of secondary stressors considerably ramp up the risk.
12
13 The other key factor is social support, the degree to
14 which we have others around us in the aftermath of these
15 events that provide support; with whom we can talk, with
16 whom we can share, with whom we can process this event and
17 who provide us with empathic and caring responses rather
18 than critical, negative and judgmental responses.
19
20 So, those factors predict - it's probably really
21 important to say, when we have done meta-analyses which is
22 analyses that have pooled all of those risk factors
23 together, the factors that come up strongest are, once we
24 start to ramp up those event-related risk factors, that
25 becomes a key determinant; but the next one down the list
26 is not what you were like before, it's the kind of supports
27 that occurred afterwards, both in terms of stressful events
28 and support.
29
30 From our perspective as an organisation, as
31 individuals focused on improving systems, that's good news
32 because that's an area we can do a lot about. We may not
33 be able to do a lot in the clinical space or in the service
34 space although this Commission will in relation to the
35 nature of the social determinants that Georgie was
36 outlining earlier.
37
38 But what we can do is do a lot to support people
39 afterwards, and we know we can get an enormous bang for
40 buck in terms of improving and supporting people in the
41 aftermath of exposure and that can make an enormous
42 difference in the terms of the trajectories of their
43 recovery afterwards.
44
45 The first words that are said to you after you're
46 exposed to an event like this can make a huge difference in
47 terms of your belief about it, your attributions about it,

1 the degree to which you felt it was your fault or not,
2 the degree to which you felt you did the right thing or
3 not, because in those first few hours or days, that memory
4 is still bubbling around in your head and you're not quite
5 sure what to make of it and you are very sensitive to what
6 the people around you say and that has a role in forming
7 the way that you think about it.
8
9 Q. I'm going to ask you a bit more about that shortly,
10 but really, just to summarise the factors that contribute
11 to the development of some kind of, I guess, an impact on
12 someone's mental health, you've said pre-event risk
13 factors, event-specific risk factors, and then finally the
14 post-event risk factors, and is it the case that, of those
15 three, the only one that can be controlled is the
16 post-event risk factors?
17 A. Look, that's true depending on where we sit: obviously
18 there's lots that we can do as a society to try and
19 mitigate as a society the social determinants, there's lots
20 we can do to try to minimise the experience of violence in
21 the community, so there's a lot we could do to try and ramp
22 down what the exposures are like and there's an enormous
23 amount that we can do there in terms of reducing violence
24 in all its shapes and forms.
25
26 From a mental health service system perspective,
27 that's right, that's where we really come into - which is,
28 what do we do afterwards? And that afterwards means in the
29 immediate afterwards, through to years, decades down the
30 track in terms of ongoing chronic mental health problems.
31 So, there's a lot we can do in that after space.
32
33 Q. What can you say about whether factors such as
34 individual resilience impact on the risk of developing a
35 disorder?
36 A. Look, resilience is a term that was used and was
37 outlined earlier, it kind of tends to mean different things
38 and it can get a bit tautological in its definitions,
39 really. When we do think about resilience we think about
40 individual factors, social factors, systematic factors that
41 build an individual and community's capability to be able
42 to flow and respond to a traumatic exposure and to either
43 maintain functioning or regain functioning.
44
45 The reality is, in the evidence base at the moment, is
46 there's we, our colleagues internationally, there's lots of
47 people in the context of trauma working in this area and

1 the reality is the evidence base is growing but it's not
2 very strong. So we don't - we are confident about what we
3 are suggesting but we don't have a very strong basis for
4 the effectiveness of it but it's growing, and they are
5 working on the individual, on the family, on the community
6 or, if you're working in an organisational setting, on the
7 organisational factors. So, we're clear enough about what
8 to try and do, it's not as though it's a complete green
9 field, we know about what to do as we build the evidence
10 base but the reality is, we're not as absolutely sure on
11 the basis of the evidence about what works in terms of
12 resilience building.
13
14 Where we become much more confident is in relation to
15 early intervention for emerging signs.
16
17 Q. Okay, and we'll get to that in a moment. In terms of
18 this concept of early intervention, why is it important in
19 this context?
20 A. For two reasons: one is, if we can intervene in the
21 trajectory very early on, then the mitigation and
22 minimisation of pain and suffering on an individual level
23 is enormous. So that, we know that, in terms of the
24 developments of PTSD, the risk of developing PTSD if we
25 don't intervene for someone who's experiencing those
26 problems or early signs of those problems and using PTSD
27 just as a working example - as I said there's all manner of
28 mental health problems that can emerge afterwards, but just
29 using PTSD as a working example.
30
31 We know that, for example, PTSD causes pain and
32 suffering in its own right, it impacts on work, it impacts
33 on family, it has multigenerational effects. The only
34 problem is it also doesn't stay just as PTSD. People with
35 PTSD tend to accrue other problems like depression,
36 substance use, and then as circumstances around them start
37 to struggle, from family, from a vocational perspective,
38 then that further increases the likelihood of mental health
39 problems.
40
41 Part of the concern is, unless we intervene early,
42 we're running the risk of increasing the trajectory towards
43 significant distress, and then we start to get into the
44 nexus between PTSD, depression and substance use and the
45 risks for suicide increase significantly.
46
47 Q. How can those post-event risk factors that you

1 referred to earlier be mitigated by providing support
2 early?
3 A. So when we think about support I guess we're thinking
4 at two levels really. We don't yet have the post-event
5 universal panacea, which is, is there something we can do
6 for everybody in the immediate aftermath of an event that's
7 going to protect them? We're not there.
8
9 As you can imagine, it's the Holy Grail that we and
10 our colleagues internationally are working continually
11 trying to think about this. At a psychological and at a
12 pharmacological end is there something we can do afterwards
13 that's going to protect people from developing significant
14 mental health problems. We're not there.
15
16 What we have as international best practice, so what
17 do we do in the aftermath of an event? We have a process
18 called psychological first aid, and psychological first aid
19 is a stepped process of how to support people in the
20 aftermath.
21
22 As we said before, really importantly, people have all
23 different kinds of patterns of responses to these events
24 and the last thing we want - and people are naturally
25 resilient in many respects. As we said, 70 per cent of the
26 Australian population experience traumatic events, and a
27 far smaller number than that actually develop mental health
28 problems in the aftermath of these events and we know this
29 from the way we deal with trauma and adversity in everyday
30 life.
31
32 The last thing we want to do is intervene to cut
33 across people's natural coping strategies that work well
34 for them. So, psychological first aid is a process by
35 which we provide general advice and support, identifying
36 where people are at after an event, we're looking out for
37 some of those signs that I described to you before of a
38 shutdown or extended hyperarousal or feeling overly keyed
39 up or wound up, and we're providing some grounding or
40 calming where that might be the case.
41
42 We're providing people practical support for what they
43 need after an event, getting in contact with loved ones or
44 getting something organised for themselves and we're
45 keeping our eye on them for the first week and we're
46 looking to see whether these things settle down, providing
47 them with the support that they need on an individual

1 basis.
2
3 Q. Who provides the psychological first aid?
4 A. It depends on the context, it doesn't need to be a
5 mental health professional. So, for example, in the
6 aftermath of a natural disaster that can be - frequently
7 NGOs would provide that, Red Cross, others. In an
8 organisational context, for example they often have peer
9 support workers who will provide that. Also training for
10 managers and supervisors in providing simple psychological
11 first aid.
12
13 When the person they're supervising returns, whether
14 it be a firey, ambulance member or a police member, kind of
15 returns back after an event, the simple things that you
16 would say in order to assess, support and then watch: you
17 know, what might be different in terms of this person, what
18 they're saying, how they're acting, their behaviours, their
19 engagement, their withdrawal. Simple things you can do and
20 then support them in doing so.
21
22 So psychological first aid can be done by those who
23 are part of the person's network, and even the way the
24 families may support each other afterwards. The critical
25 part also is, allowing the person the opportunity to talk
26 about this event if they want to.
27
28 Historically, the Commissioners may be aware of a
29 process called psychological debriefing, and about 20 years
30 ago there was a view that, in the aftermath of a traumatic
31 event, it was really important to talk about the event in
32 great detail with a debriefer who was provided for you.
33
34 The reality is, we know that - we've got data now that
35 says that doesn't prevent the development of PTSD. We also
36 know that for a group of people it actually can make them
37 worse. Where their preferred method may well be to not
38 necessarily - they might want to talk about it but not
39 necessarily with the person provided for them, they want to
40 talk about it with friends, families, their mates from
41 work, whoever they might elect, and they want to talk about
42 it when they feel comfortable talking about it.
43
44 Some want to talk about it straight away, others want
45 to get back a sense of control and talk about it then, so
46 really important we don't cut across the way people respond
47 but provide the psychological first aid which gives them an

1 opportunity to talk if they want to talk and then the
2 supports that they need.
3
4 Q. You referred earlier to the idea of watching. So,
5 after this initial, I guess, psychological first aid and
6 the response that's involved there, is the next phase a
7 term known as watchful waiting?
8 A. And watchful waiting is just, as you're providing that
9 support you're keeping your eye out for changes in
10 behaviour, emotion and how the person is settling over the
11 course of those first days and weeks, and with a view that,
12 in about a week or two weeks if the person is still highly
13 distressed, that's an indication for a more formal early
14 intervention response, and there we're starting to move in
15 territories like, for example, treatment of acute stress
16 disorder which can be diagnosed between two days and four
17 weeks, or posttraumatic stress disorder, and there our
18 evidence becomes much stronger also about what to do to
19 best treat that person at that time.
20
21 Q. We'll come back to that in just a moment. I just want
22 to ask you before we do about trauma-informed care and how
23 that fits in what you've been talking about.
24 A. So, trauma-informed care is something that applies all
25 the way across the spectrum and probably something that
26 I'll also come back to later, which is, trauma-informed
27 care is not a formal treatment but it's recognising that
28 for people who have been affected by trauma, they are
29 likely to be responding in certain ways, they'll be more
30 sensitive to the way that they're spoken to, particularly
31 in the nature of their experience, particularly if their
32 experience is one of physical or sexual abuse or childhood
33 abuse, they're very conscious about the way in which they
34 are spoken to, the cues and triggers that are used in
35 conversations.
36
37 So trauma-informed care is really around being aware
38 of what the cues and triggers are and finding ways to
39 interact with the individual or the person with PTSD for
40 example to minimise the degree to which those interactions
41 are setting off these cues and triggers in terms of their
42 emotional reactions.
43
44 So an example of that could be, within health service
45 systems for people working with substance use disorders,
46 many of them are trauma exposed, many of them have PTSD.
47 The interaction might be around substance use but being

1 aware of the degree to which the person might also be
2 trauma exposed and that can influence the treatments you
3 use.
4
5 Or even in the broader service system with
6 homelessness services, with forensic systems, with judicial
7 systems, legal systems, how one interacts with a person
8 who's trauma exposed can make a huge difference in terms of
9 how they experience that interaction, the degree to which
10 it is calming for them or makes them worse, and indeed
11 their capacity to get value out of that interaction where
12 you're able to even communicate the information you are
13 wanting to communicate.
14
15 The likelihood of the person with PTSD understanding
16 what you're saying if what you're saying is replete with
17 cues around their trauma, the likelihood is their head has
18 gone to the trauma place and they've stopped being able to
19 process what's being said.
20
21 So, really important around trauma-informed care and
22 that can occur across all of the system. It's not about
23 treating PTSD; it's about knowing about how do you talk to,
24 how do you set an environment that's comfortable, and how
25 do you support someone who's trauma affected in the work
26 that you're trying to do, whatever that may be: health
27 related or more broad.
28
29 Q. And that's something that can be trained?
30 A. Definitely.
31
32 Q. I'll come back to ask you about that later. Just in
33 terms of the best practice when it comes to early
34 intervention into trauma-related mental illness; you began
35 to talk about this earlier in the context of treatment for
36 acute stress disorder and PTSD. Can I just take you back
37 to really talk about when there might be a diagnosis, for
38 example, of acute stress disorder?
39 A. So, for example: so, acute stress disorder can be kind
40 of diagnosed between two days and four weeks, and the
41 symptoms of acute stress disorder are: memories keeping
42 coming back about the traumatic event, trying hard - being
43 distressed at reminders of it, trying hard not to think
44 about it, or feel anything, trying to shut it down.
45
46 And simultaneously with all of that, a sense of being
47 very keyed up or on edge and kind of almost ready for

1 another event to happen: so, sleep problems, concentration
2 problems, hypervigilance, so a sensitivity for where people
3 are and where your safety points are, being easily
4 startled, so these are kind of some signature features of
5 acute stress disorder, for example, and we do have good
6 evidence-based treatments for acute stress disorder and
7 posttraumatic stress disorder.
8
9 Q. Just in terms of the progression, if the symptoms
10 you've described persist for four weeks or more, is that
11 when there may be a diagnosis of posttraumatic stress
12 disorder?
13 A. So, after four weeks, you would make a diagnosis of
14 posttraumatic stress disorder. Between two days and four
15 weeks it would be a diagnosis of acute stress disorder.
16 There are minor differences between the two, but they're
17 largely inconsequential; it's more an issue about time.
18
19 Q. And duration?
20 A. Yeah.
21
22 Q. So, you were going on to talk about the treatments for
23 acute stress disorder and posttraumatic stress disorder.
24 There are four treatments that are recognised globally as
25 best practice when it comes to the treatment?
26 A. Yeah.
27
28 Q. Can you briefly just say what they are?
29 A. Sure. So, internationally, so in our Australian NHMRC
30 guidelines are international guidelines, and we've just
31 finished the International Traumatic Stress Society
32 guidelines, of which I'm Vice Chair of that process.
33
34 So there are four key treatments, all of them are what
35 we call trauma focused psychological therapies. At the
36 moment the strongest evidence is four psychological
37 therapies. The names of them are: prolonged exposure
38 therapy, cognitive processing therapy, eye movement
39 desensitisation reprocessing therapy, and cognitive
40 therapy. Probably they are remarkable for their
41 similarities rather than their differences.
42
43 The core elements of all of those therapies really are
44 in a safe and supported way, hand-in-hand with the person
45 with PTSD is to do three things: one is to address to help
46 them work through the traumatic memory itself. They have
47 been through an event, they have this repeated traumatic

1 memory that is causing them an enormous amount of distress
2 and destabilising their lives and impacting on their
3 relationship with others and functioning. It's helping
4 them to confront and work through that event in a safe and
5 supported way.
6
7 One of the key features of posttraumatic stress
8 disorder and these traumatic stress responses is what we
9 call avoidance, which is: I don't want to think about it, I
10 don't want to talk about it. But what we know from
11 evidence is the more we try and push it away the more it
12 tends to bounce back. So a really core part is helping the
13 person work through that.
14
15 The second part is, traumatic events like the ones
16 that I've described dramatically effect the way we think
17 about ourselves, the way we think about humanity and our
18 relationship with other people, the degree to which we
19 trust other people or not, and the belief about the world
20 in which we live. And so that also within PTSD can get
21 stuck in a way that's hampering recovery.
22
23 So, the second part of treatment actually helps the
24 person work through, how are they thinking about this event
25 in relation to themselves, their relationship with others
26 in the world, and helps them work through that to a
27 position that's orientated towards recovery.
28
29 The last bit is, the person starts to organise their
30 life, small at first but then it grows, which is organise
31 their life away from anything that reminds them of what
32 happened and they start to avoid potentially more and more
33 things and their life starts to shrink and shrink and
34 shrink over time.
35
36 The last part is what we call in vivo exposure or
37 dealing with experiential avoidance, which is helping
38 mapping out for the person all the things that they avoid,
39 particularly things that impact on their lives, being able
40 to go past a cue, but that cue that they're avoiding was on
41 the way to being able to pick the kids up from school, so
42 now they don't pick the kids up from school. Now I don't
43 work where I used to work because it's got that cue.
44 Things that impact their life dramatically.
45
46 Their capacity for meaning and functional roles, and
47 we map those out and we help the person gradually start to

1 reclaim those events and start to do those events again.
2 So, we're not only bringing symptoms down, we're actually
3 trying to regain full levels of functioning.
4
5 So all of those three things are done hand-in-hand
6 through all of these therapies in different ways. As I
7 say, the similarities are more obvious than their
8 differences.
9
10 Q. What is known about the clinical effects of those
11 treatments?
12 A. So, we get very large clinical effects. By and large
13 what we would see is about - and these are the best we have
14 - about a third of people with PTSD would recover
15 completely from their PTSD. About a third will get
16 significant improvements but still have some ongoing
17 problems, and for a third of people that first dose of
18 treatment may not be adequate and may not change things
19 much.
20
21 Particularly when we start to talk about, for example,
22 in asking before about complex trauma and complex PTSD,
23 which starts to include when we talk about repeated and
24 ongoing trauma, both whether it's as a child
25 developmentally or as an adult, repeated ongoing trauma,
26 particularly of an interpersonal nature, physical or sexual
27 abuse, and we develop something with a core complex PTSD,
28 we start to see more difficulties in managing emotions,
29 more difficulty in managing interpersonal relationships and
30 more difficulty also, and more impact in terms of self
31 perceptions, thinking negatively, deeply negatively about
32 one's self.
33
34 So in the context of those that have complex PTSD we
35 have targeted interventions to support the interventions I
36 just described to you. But by and large we talk about
37 responses, the rule of thirds. We and others are pushing
38 hard at trying to identify how do we get better adjuncts to
39 these treatments, how do we get new treatments that
40 actually also might improve that third who aren't
41 responding currently; there's lots of activity in that
42 space.
43
44 The biggest issue I guess that's worth flagging though
45 is, even with those best treatments we have, the reality is
46 that a number of practitioners out there who are trained up
47 and skilled in delivering these best practice treatments is

1 extremely limited and the likelihood of someone with PTSD
2 going to see their local practitioner, mental health
3 practitioner and getting one of those treatments is about
4 30 to 40 per cent.
5
6 Q. What about the training in these treatments then in
7 that profession? Is it readily available or not?
8 A. So, in clinical training it's mentioned but mentioned
9 briefly. Training is available for practitioners but often
10 it's not widely available. The other issue that I'm sure
11 we're likely to come to later on is the issue about
12 availability of actual services for trauma survivors to
13 access who could deliver these treatments.
14
15 Q. What kind of services are you talking about?
16 A. So currently the way, if we're talking - currently the
17 way services are set up within Victoria, for example, is if
18 you have - there's the Centres Against Sexual Assault which
19 provide support for you if you have - if your trauma has
20 been a sexual assault. There's support services for
21 veteran and military personnel funded through DVA, or
22 through health insurers, through WorkSafe if you're exposed
23 at work, or alternatively through Foundation House for
24 example for refugees and asylum seekers.
25
26 Part of the issue is, unless you fall into one of the
27 designated categories that a service has been set up for
28 you, or your recovery is funded through an insurers, the
29 Transport Accident Commission for example, there's no clear
30 pathway to, where do you get this best practice treatment.
31
32 Currently within the mental health service system
33 within Victoria, community mental health and hospital based
34 mental health is really focused on serious mental illness,
35 and that's extremely important, but posttraumatic stress
36 disorder and trauma related disorders of the high
37 prevalence variety, PTSD, anxiety, depression,
38 posttraumatically tend not to be treated within community
39 mental health environments, hospital or in mental health
40 community settings.
41
42 So, unless you fall into one of those categories of
43 specific funder or specific type of exposure, there isn't a
44 clear place that you might go to for care. There is the
45 Commonwealth Medicare system which is six sessions plus
46 four. The minimum dose, the minimum effective dose for the
47 treatment of PTSD, even mild to moderate PTSD, is ten to 12

1 sessions, and that's the minimum mild effective dose. When
2 you're talking about complex problems it gets much more
3 significant.
4
5 Q. You said the ten to 12 sessions, you're talking about
6 weekly sessions?
7 A. So weekly sessions would be commonly used. We are
8 currently trialling and our colleagues internationally are
9 currently trialling can we do so in a more intensive way.
10
11 So, for example, we're doing a trial at the moment
12 through Veterans Affairs, Defence and NHMRC to say, well,
13 ten weekly sessions versus ten sessions over a two-week
14 period, what are the equivalent - are we getting equivalent
15 effects and what does that mean and can we then provide
16 this as an option for trauma survivors with PTSD so the
17 people can choose around what kind of effectiveness and
18 whether they what to do an immersed, more intensive
19 experience or whether they'd prefer it to be spaced out,
20 but at the moment we don't have strong evidence around
21 that.
22
23 Q. But in any event, the minimum required is between ten
24 and 12 sessions?
25 A. Yep.
26
27 Q. What about funding of those services?
28 A. So, at the moment - funding as in what funding exists
29 for those services?
30
31 Q. What funding needs to be provided for those services?
32 A. Well, one possibility is the question of funding; the
33 other question is, are there parts of the existing service
34 system whereby the treatment of posttraumatic stress
35 disorder might be able to be located?
36
37 One example, Victoria is richer than other states in
38 having community health centres around the state, and those
39 community health centres have a mental health capability,
40 but they wouldn't routinely be set up where the mental
41 health capability would be trained up and able to treat
42 posttraumatic stress disorder of whatever its origin.
43
44 So one is the potential, and whether it's this
45 Commission or elsewhere, to be lobbying at a federal end in
46 terms of Medicare for moderate PTSD or severe PTSD to
47 increase from six plus four sessions to something that

1 looked like it would be an advocate dose in terms of making
2 it available to trauma survivors.
3
4 The other is also thinking more broadly about where
5 within the health and mental health service system within
6 Victoria, we can have a skilled-up capable workforce
7 embedded within these existing structures and services to
8 be able to deliver PTSD treatment at a local community
9 level within a local multidisciplinary health environment.
10
11 Q. That could then also encompass referral pathways?
12 A. Indeed.
13
14 Q. And also the delivery of trauma-informed care which
15 you spoke about earlier?
16 A. That's right, that's right. So, at a minimum we would
17 want the community mental health services and community
18 health services, even without that embedded capability, to
19 be trauma aware, trauma informed, in relation to people
20 from the community that they're dealing with that have been
21 exposed to trauma and being aware and sensitive to how to
22 speak, what their needs might be and what triage and
23 pathways might look like.
24
25 At the moment we at our centre, and this is shared
26 from my colleagues around the country, but speaking from
27 Victoria, we will get calls all the time from people with
28 PTSD who don't fall into one of those specific funded
29 agencies, and so, where do I go for treatment?
30
31 And we might be able to identify a provider or two
32 providers here or there, but in the absence of a funding
33 line to support it, if they don't have an insurer backing
34 and it's very difficult, and they're getting the Medicare
35 six plus four, and even finding the number of providers out
36 there with skills in being able to treat PTSD, which is a
37 unique set of skills, and make an enormous difference to
38 trajectory. It's rare.
39
40 So, the potential to use this forum to be able to
41 build the capability around the capacity to treat PTSD,
42 funding lines or embedded in service systems that might
43 exist already to make that accessible to the community
44 irrespective of their kind of exposure.
45
46 Q. An example of someone who may not fall into one of
47 those established streams is an adult survivor of physical

1 or sexual abuse?
2 A. Potentially. A natural disaster survivor, for
3 example, yeah.
4
5 Q. Just finally, one of the things you mention in your
6 statement that's been provided to the Commission is that
7 the system needs to be more adaptable to change. Can you
8 just explain that, please.
9 A. I think in an area like posttraumatic stress and
10 trauma, where we are learning more all the time about its
11 impact, and having clear mechanisms whereby new information
12 can be fed back into the service system to be able to - one
13 is, you know, I was describing before, the gap between best
14 practice and routine care at the moment and expressing some
15 concern about that gap. But even then, once we address
16 that gap, the critical part is around prevention, around
17 early intervention: at hospitals, accident and emergencies.
18
19 As we learn more about - we've got psychological first
20 aid now, building up their capability and that now, but as
21 we learn more around evidence-based practices that more
22 confidently and specifically can influence the trajectories
23 and protect people in the aftermath of trauma, a mechanism
24 by which they can be fed back on a state basis. And at the
25 moment that's fairly piecemeal in the way that that would
26 occur. It really is about engaging each agency on its own
27 rather than having a coordinated state response across the
28 different manner of exposures and as it's reflected in
29 different parts of the mental health service system and
30 other jurisdictions coming under the control of state: for
31 example, justice.
32
33 MS COGHLAN: Thank you. Chair, do the Commissioners have
34 any questions?
35
36 COMMISSIONER McSHERRY: Q. Thanks, professor, for that
37 evidence. Just a quick question, and it may be beyond the
38 scope of your expertise, but I understand in relation to
39 natural disasters in particular there's an emerging
40 literature about posttraumatic growth.
41 A. Yes.
42
43 Q. I'm just wondering, is there anything that we can
44 actually hone in on in terms of supports for people that
45 might lead to that growth: that people not only recover,
46 but they flourish?
47 A. M'mm. Look, thank you for the question. Absolutely.

1 So, the area of posttraumatic growth, so the idea that when
2 we're challenged by events we kind of develop and adapt in
3 different ways and develop an ability to extend ourselves
4 psychologically, emotionally, relationally; it's growing.
5
6 There is an evidence base now behind posttraumatic
7 growth. It's observed as a phenomenon, so we see it there.
8 Interventions to promote posttraumatic growth are not
9 strong but there's attention towards it.
10
11 But a very simple way is actually even orienting
12 people to the idea that these events challenge us in
13 different ways and not just thinking in a way that, you
14 know, the only impact it has is nothing at all or damage:
15 the idea is actually we all extend out of these events as
16 well and pointing people to it.
17
18 Writing therapy, for example, is used a lot in
19 relation to promoting: how has this event changed you? And
20 in thinking about this, we want you to be thinking about:
21 how has this changed you? Do you see the world in a
22 different way? Are there some ways in which you see your
23 own personal strengths in different ways? Are there ways
24 in which you see the meaning of life differently and the
25 things that you might value into the future differently?
26 So there's ways to facilitate that.
27
28 The intervention is in its fledgling stage but I think
29 posttraumatic growth as a phenomenon is now gaining a lot
30 of currency. We co-host a conference every two years, the
31 Australian Conference on Traumatic Stress and we'll be
32 inviting out for that - the keynote for that is Professor
33 Richard Tedeschi who is probably one of the lead
34 researchers and clinicians in the area of posttraumatic
35 growth. So, if that's of interest to the Commission, I
36 would encourage you to hear Richard and we can also try and
37 make him available to you as a group.
38
39 COMMISSIONER McSHERRY: Thank you very much.
40
41 CHAIR: Q. There are other points I'd like to ask,
42 professor. The first is, you've talked a lot about the
43 impact and availability of these sort of interventions and
44 the need for a greater skilled workforce. Can you talk to
45 the issue of how able we are to deal with these issues and
46 have both the models of care and the practitioners
47 available to work directly with children who might be

1 exposed to, directly and/or witnessed, extreme violence and
2 other circumstances?
3 A. In terms of the availability of the workforce to work
4 around children?
5
6 Q. And the efficacy of the intervention?
7 A. And the efficacy. So, there are - so, the kinds of
8 interventions I described before are consistent for
9 children and adolescents as well as for adults, so those
10 principles.
11
12 How traumatic stress is expressed in kids is
13 different. We tend to think more about internalising and
14 externalising symptoms amongst kids. But those treatments
15 have a good evidence base around kids and adolescents as
16 well. The evidence base is smaller but still clear that
17 trauma-focused cognitive behaviour treatment is our best
18 and most effective method for kids.
19
20 The degree to which the child and adolescent mental
21 health services? They're certainly more trauma aware than
22 the adult mental health services might be, and certainly
23 open to the way in which trauma might be managed. Having
24 said that, I still think that there would be value in
25 thinking about how to build and enhance the capability of
26 CAMHS services for example in relation to trauma awareness,
27 trauma-informed care, and then the potential to actually
28 build in primary trauma related mental health
29 interventions. I'd see all those three things as three
30 capabilities to potentially enhance within child and
31 adolescent services.
32
33 And also, there's kind of accident and emergency
34 within the Royal Children's as well which is very trauma
35 aware and would be a leader, in my view, in terms of - if
36 anything was done in the state around CAMHS, that the
37 trauma unit at RCH would be a terrific partner in that.
38
39 Q. Thank you. As a follow-up, though, we've also heard
40 in the course of the last few days in our community
41 consultations that, whilst increasingly we understand
42 intervening early to change the trajectory that you have
43 spoken about this morning is important, many people have
44 still faced barriers.
45
46 One of them can be a reluctance to acknowledge the
47 experiences they have had or a view they have to suck it up

1 and just deal with it. Do you think that's changing? Do
2 you think that we are having people more aware of the needs
3 for them to acknowledge and get early help?
4 A. I think it's changing, I think it's still a barrier,
5 definitely still a barrier. So, for example, we have just
6 done - well, call it Pathways to Care, a study with
7 Defence, for example, so young Defence members. Now, that
8 has come some way, for example, in terms of attitudes to
9 help seeking and care seeking, but there's still a long way
10 to go in relation to people's preparedness to acknowledge
11 the difficulties.
12
13 Particularly when it comes to trauma exposure
14 specifically, there's the sense that I should be able to
15 handle this. And, when's the right time and what are the
16 cues for knowing when my difficulties have gone on long
17 enough and it's time to seek help.
18
19 And critically a belief in the effectiveness of help,
20 which I think is as much a part of it as anything. That's
21 certainly what we've found in our work as well, which is,
22 this inter-relationship between preparedness to -
23 recognition of a problem, preparedness to help seek, but
24 also the belief in the effectiveness of the system to help
25 you.
26
27 And where that third part isn't there, it really ramps
28 up vulnerabilities on parts 1 and 2, which is, there's no
29 point really thinking about it, there's no point looking
30 inside and there's no point asking for help if I don't have
31 a belief in that. And at the moment we're falling down a
32 bit in part 3. We've worked very hard on parts 1 and 2,
33 but trying to convey the message that we've got good
34 treatments out there that are available and can help you;
35 that bit goes a long way to then addressing it.
36
37 What we've found in some of the other stuff, research
38 we've done, is that people, despite their reluctance to
39 seek care, one, appointed there often by family and
40 friends, but secondarily will seek care anyway if they
41 think it's going to help them, even if they don't want to.
42 Even if they fear it's stigmatising, they'll do it if it's
43 going to work, but what's going to stop them going through
44 the pain and suffering, of the stigma of seeking care, is
45 if the feel like it's not going to help them anyway.
46
47 In the area of PTSD that's a big problem specifically

1 because of the availability of effect - availability of
2 treatment and messaging around effective treatment
3
4 CHAIR: Thank you very much.
5
6 MS COGHLAN: Thank you, professor. May he be excused?
7
8 CHAIR: Yes.
9
10 <**THE WITNESS WITHDREW**
11
12 MS COGHLAN: Chair, is now a convenient time to break for
13 lunch? The next witness will be called at 2pm and that's
14 Melanie Hill.
15
16 CHAIR: Yes, adjourn.
17
18 **LUNCHEON ADJOURNMENT**
19
20 **UPON RESUMING AFTER LUNCH:**
21
22 MS COGHLAN: The next witness to be called is Melanie
23 Hill. Her evidence is the subject of a non-publication
24 order. Chair, will that order be made now?
25
26 CHAIR: Yes. The Royal Commission has made an order
27 pursuant to the Inquiries Act 2014 prohibiting the
28 publication of any information that might identify the next
29 witness who is about to give oral evidence to the
30 Commission.
31
32 The witness will be referred to as the pseudonym
33 "Melanie Hill" and her daughter as "Natasha Hill" and those
34 are the pseudonyms that will be used throughout this
35 hearing today.
36
37 I would like to remind all persons present, including
38 the media, that any material which would enable the
39 identification of this witness cannot be published.
40
41 The hearing of Ms Hill's evidence will be limited to
42 those people attending today's hearing. For those watching
43 on the live stream, there will be no live streaming of this
44 portion of the evidence. A copy of this order has been
45 placed on the door of the hearing room and, once the live
46 stream has been cut, counsel may please call the witness.
47

1 MS COGHLAN: Thank you, Chair.
2
3 (Live stream cut.)
4
5 MS COGHLAN: I call Melanie Hill.
6
7 <**MELANIE HILL, affirmed and examined: [2.03pm]**
8
9 MS COGHLAN: You're giving evidence today under the name
10 of Melanie Hill?
11 A. Yes.
12
13 Q. And you provided a statement in that name with the
14 help of the Commission?
15 A. Yes.
16
17 Q. I tender that statement. [WIT.0001.0013.0001]
18 Melanie, you have a daughter who is currently 16 years old?
19 A. Yes.
20
21 Q. And she suffered from mental health issues that impact
22 pretty much every aspect of her life?
23 A. Yes.
24
25 Q. She currently has a diagnosis of borderline
26 personality disorder?
27 A. That's correct.
28
29 Q. When did she first receive a diagnosis of any kind?
30 A. Aged 9.
31
32 Q. And so, between the ages of 9 and 16, can you please
33 tell us what diagnoses she's had?
34 A. Started out with generalised anxiety disorder,
35 oppositional defiance disorder, separation anxiety, conduct
36 disorder. Moved through an autism assessment. She was
37 assessed as being on the spectrum, not formally. And we
38 had another therapist tell us that they believed she had
39 pathological avoid and demand disorder which is on the
40 spectrum.
41
42 Then we got - then she got the diagnosis of borderline
43 personality disorder. Since then she's also received an
44 anti-social personality disorder diagnosis.
45
46 Q. And so, your family's had a lot of contact with the
47 Victorian mental health system over the years?

1 A. Yes.
2
3 Q. How would you describe that experience?
4 A. Our experience has been shockingly inadequate.
5
6 Q. I'm just going to take you back to the time when your
7 daughter was 8 or 9 years old and just ask you really to
8 detail for the Commissioners, how she was presenting at
9 that time, what was happening?
10 A. We first started seeing signs of anxiety, trouble
11 leaving my side. She started having behavioural issues as
12 well, and then the panic attacks started with what I
13 believed to be looking like dissociative features with that
14 panic attack, those panic attacks.
15
16 Q. In what way? Can you describe what it was?
17 A. It felt like she was losing touch with reality when
18 she was having those panic attacks. So, not only was she
19 thinking that she was going to die, she was not feeling
20 like she was in the world, that the world was black and
21 white, that her brain needed to be taken out and washed and
22 she was really scared and wanted to go to hospital a lot
23 because she was incredibly terrified what was happening to
24 her in her mind.
25
26 Q. Okay. And at that age, you took her to see a private
27 psychologist?
28 A. Yes.
29
30 Q. And that was - after that time things did escalate in
31 the public system, but can I just ask you about that
32 experience with the private psychologist and how that went?
33 A. Sure. My daughter had numerous sessions with the
34 private psychologist, and I was never asked to be a part of
35 any of those sessions. We were given anxiety and anger
36 management books to do at home.
37
38 Q. How did that go?
39 A. It was disastrous.
40
41 Q. By that, do you mean that you didn't do them, or you
42 couldn't do them?
43 A. There was just a - I was just met with refusal which
44 increased the conflict in the home.
45
46 Q. What about your first experience with your daughter
47 with the hospital system; when was that?

1 A. Yes, that was when she was around the age of 9, when
2 she had her first panic attack and she'd asked to go to the
3 hospital. And, I had no idea where to take her and we
4 ended up going to the psychiatric ward at that hospital; I
5 didn't know that you had to go through the ER to access
6 psychiatric care.
7
8 So, we went down to the psychiatric ward and sat there
9 for quite some time and then were told, no, you have to go
10 through the ER. And we sat there for hours and hours to
11 wait for a - the assessment team to come. During that time
12 there were - there was lots of commotion and a couple of
13 people in there were affected with drugs and causing a lot
14 of disruption in the hospital, it was quite scary for my
15 daughter at that time.
16
17 It was probably after 1 o'clock in the morning that we
18 got to see a team. They did an assessment which was really
19 just based around any suicidal thoughts and sent us home
20 Q. And, with what supports?
21 A. No supports. I'd accessed the triage number before
22 the incident at the hospital and we were linked in to a
23 service, the Child and Adolescent Service, but we didn't
24 have a follow-up call after that.
25
26 Q. Okay. The experience you've just described at the
27 emergency department, was that a common theme over the next
28 couple of years?
29 A. Yes.
30
31 Q. And you experienced that time and time again?
32 A. Time and time again. Long, long, substantially long
33 waiting periods.
34
35 Q. And at no point was your daughter admitted to
36 hospital, at that stage?
37 A. At that time, no.
38
39 Q. Can I ask you then if we move forward in time to when
40 your daughter was about 12, when things escalated for her.
41 Can you just describe in what way they escalated?
42 A. Sure. On the Labour Day long weekend of 2015 my
43 daughter went missing. When we found her later that day
44 she was quite dishevelled, she didn't really understand why
45 we were looking for her and why we were distressed.
46
47 She would only get in the car if we took her to

1 hospital because she wanted to be hospitalised because she
2 was saying that there were some disturbing thoughts going
3 on in her mind.
4
5 On the way to the hospital my daughter was quite
6 agitated and was assaulting my father and at the same time
7 was trying to cut her wrists with a shard of glass that she
8 had held onto. She was also stating that she had a plan to
9 kill her younger brother at that stage, and her voice was
10 very different and it was an incredibly scary situation for
11 all of us.
12
13 Q. And so, did you go to the hospital on that occasion?
14 A. Yes.
15
16 Q. And just describe what happened, please?
17 A. I parked the car out the front and asked if we could
18 get someone to go out to the car to get her; we had
19 security guards come out. We waited a very, very long
20 time, many, many hours. We arrived there around dinner
21 time and she was assessed by a nurse, who received advice
22 from an on-call psychiatrist that we had never met before,
23 and we were told, it was probably around 1 o'clock in the
24 morning by this stage, that this was conduct disorder, that
25 she would not be admitted and that she was not to return
26 home for the safety of my son and her only options were to
27 live with her father or to go into residential care.
28
29 Q. Alright. So, at that time you didn't speak to a
30 psychiatrist or?
31 A. We never spoke to a psychologist - a psychiatrist, and
32 we had minimal contact with a mental health nurse.
33
34 Q. Alright. So, as a result of what you were told at the
35 hospital at that time, that she wasn't to return home, did
36 she end up going to live with her father in Melbourne?
37 A. Yes.
38
39 Q. And you were at the time living two hours away from
40 Melbourne?
41 A. Pretty much.
42
43 Q. How long did she stay with him, first of all?
44 A. It only lasted five weeks.
45
46 Q. From there, she went to live with an aunt who was in
47 Melbourne?

1 A. With an aunt, yes.
2
3 Q. And all this time you're living still two hours away?
4 A. Yes.
5
6 Q. And so, what were you doing at that time to try and
7 get your daughter the help that you saw that she needed?
8 A. I remember just trying to call every single service
9 that I could think of; I was just so shocked that I
10 couldn't access any services for my daughter because, the
11 only way we were able to - it was my understanding that the
12 only way we were able to have her come home is with
13 treatment for these thoughts, and it was very difficult to
14 find any service that would take her on apart from Child
15 and Adolescent Mental Health Services, but they will only
16 work with a child if they engage with the service.
17
18 Q. Okay. So, at that time your daughter was not
19 engaging?
20 A. She wasn't engaging. We did see - I did, on the
21 advice of someone I respected, find a psychiatrist on the
22 other side of the city and my daughter saw him a couple of
23 times, but then she refused to go back, but my daughter's
24 aunty and myself continued to see him to get the support
25 that we needed to try and respond therapeutically and
26 understand what was happening for her at that time.
27
28 Q. What was the - was that something you had to pay for
29 yourself or?
30 A. Yes, it was very expensive, over $300 a session.
31
32 Q. Following on from that, you also attended a group for
33 carers?
34 A. Yes, a 12-week Family Connections support group for
35 people with borderline symptoms and behaviours, which was
36 fantastic.
37
38 Q. So, what gains were made, if any, in that time that
39 your daughter was living with her aunt in Melbourne for
40 that year?
41 A. What gains?
42
43 Q. What gains, if any?
44 A. No, everything - everything declined - there was just
45 a rapid decline in her mental health during that time.
46
47 Q. Where did your daughter then go after having lived

1 with her aunt for that year?
2 A. She ended up in residential care.
3
4 Q. Can you just describe what that was like for her?
5 A. Oh, it's an incredibly traumatic experience for her.
6 At that time she chose to sleep rough and be on the streets
7 more than be in a residential home. So, she was more so on
8 the streets than she was - for a six-month period of time
9 than she was in any home.
10
11 Q. Okay. And so, what did she tell you about that time,
12 say six months that she was living on the streets, and how
13 was that for her?
14 A. She experienced incredible trauma that she wouldn't
15 elaborate on. Incredible ongoing trauma that she was
16 exposed to and exposed herself to. She was using drugs,
17 and she was really struggling. I was struggling to contact
18 her, and I didn't know where she was most of the time.
19
20 Q. And, she was 14 years old at this point?
21 A. Fourteen.
22
23 Q. There was a time that your daughter then went into
24 secure welfare?
25 A. Yes.
26
27 Q. And so, what does that involve?
28 A. Secure welfare has very strict criteria to access.
29 You have to be in danger. It can't be just for mental
30 health or criminal or drug use, it has to be because your -
31 her safety is at risk, she's putting herself in danger.
32 That was a really positive experience for Natasha to go
33 there. She was contained, she was safe, she detoxed off
34 the drugs, she had access to education, she wasn't alone,
35 and she improved and really benefitted from being in that
36 contained environment without the choice of leaving.
37
38 But because she did so well, she was the first person
39 to be exited when they needed a new bed, so she only lasted
40 a week. She was only there for a week, that's all they
41 could hold her for.
42
43 Q. So she spent a week in secure welfare?
44 A. The first time, yes.
45
46 Q. And on this first occasion, where did she go after
47 that?

1 A. She went back to residential care/back to the streets.
2
3 Q. And there was an occasion where she ended up in foster
4 care for one night?
5 A. Yes.
6
7 Q. Can you just tell the Commissioners about that,
8 please?
9 A. A week prior to my daughter going into foster care she
10 had called me and was incredibly distressed and gravely
11 ill, was the term that comes to mind, and I'd gone to
12 Melbourne to care for her for six - for a week before she
13 went into foster care due to her declining mental health.
14 And I was alerting services, saying, I'm gravely concerned,
15 I really feel like she's going to do something to hurt
16 herself. And I didn't feel like anyone was listening.
17
18 And, the night that she went in I stayed in Melbourne
19 and slept in my clothes because I had a feeling that she
20 would be at risk, and I received a phone call that night
21 from the hospital. Natasha had - she had self-harmed
22 incredibly up and down her arms and the foster family
23 called the police and she was so irritated and agitated and
24 distressed, she ended up throwing a packet of pasta towards
25 the police and she was pepper sprayed and taken to the
26 hospital.
27
28 Q. And what was her care then like when she was taken to
29 hospital on that occasion?
30 A. She - her wounds were cleaned and she was sent home
31 with a sleeping tablet. I was told that this was very
32 serious and her circumstances were very serious, but that
33 she would not be admitted, because they don't see people
34 with these symptoms, they don't think that it's therapeutic
35 for them to be hospitalised.
36
37 Q. So, she was sent away from the hospital then. Was
38 there an expectation at your end that there would be some
39 form of follow-up?
40 A. Yes. Yes, they told my daughter that she would need
41 to engage with services that would be calling first thing
42 in the morning to make sure that she was okay and, if she
43 didn't, that she would be sent to hospital against her
44 will. So, I was expecting a call the next morning first
45 thing, and I never received one.
46
47 Q. So, where did you go to from there?

1 A. I tried to hold her at her aunty's with us for the day
2 as long as I could, and I spoke to the hospital in the
3 afternoon and wondered why they hadn't called, and they
4 said that there was no notes on the system to say that they
5 would call, and that I needed to follow a crisis plan; and
6 I said, "I don't have a crisis plan", and that was pretty
7 much the phone call and she took off after that back to the
8 streets. I couldn't contain her any longer.
9
10 Q. And so, how long did she then stay back on the
11 streets?
12 A. Maybe a couple of months. She'd ended up back in
13 secure welfare.
14
15 Q. And how long for that second time was she there?
16 A. I got a phone call saying that I had to pick her up
17 the day before after one - the morning of her being there
18 for less - for five days, and it was at that time that I
19 realised that I needed to make some big changes to be able
20 to support her.
21
22 Q. And so, what were those big changes you made at that
23 time?
24 A. So, it coincided with my daughter being assaulted and
25 breaking up with her boyfriend that she went into secure
26 welfare, and she was open to the idea of coming to live
27 with me and that looked like me moving from the family home
28 and getting my own rental property to care for her, which I
29 did.
30
31 Q. So, you left your partner and son at the family home
32 and moved with her separately?
33 A. Yes.
34
35 Q. To a rental property to live?
36 A. Yes.
37
38 Q. How long did you live in that rental property with
39 her?
40 A. Fourteen months.
41
42 Q. And, how did that go?
43 A. Things went really well in the beginning, and she
44 stabilised, engaged with a therapist, went to school,
45 repaired the relationship with my son and my partner and
46 myself, but due to her social anxiety she started using
47 drugs again.

1
2 Q. I'll just come back to that in a minute. You've just
3 talked about going to school. What had her schooling been
4 like up to that point, in terms of attendance?
5 A. The transition from primary school to high school was
6 quite contrasting between the two: really high attendance
7 in primary school, and Year 7, probably about 80 per cent
8 and then Year 8, she hasn't attended school pretty much
9 since Year 8 and she should be in Year 11 now. We've had
10 small stints and tried different alternative options but,
11 due to social anxiety, it's been a real struggle.
12
13 Q. So, you've just been talking about the 14-month period
14 where you've been living together in the rental property.
15 You talked about at the end of that or towards the end of
16 that your daughter had started using drugs again, and that
17 then escalated into self-harm as well?
18 A. Yes, that's when the self-harm started becoming to a
19 point where stitches were needed at the hospital. So, it
20 went from superficial to quite deep.
21
22 Q. And again, the hospital attendance, how did that go?
23 A. Again, long wait periods. It really did feel like we
24 were being pushed to the bottom and people were coming in
25 with minor injuries that were being seen before us; to the
26 point where I felt that I needed to ask the doctor if we
27 were being treated like this because it was self-harm.
28
29 Q. What was the response?
30 A. He said, "No", but yeah.
31
32 Q. Did it feel like a punishment in a way?
33 A. Yeah, yep.
34
35 Q. Your daughter's behaviours escalated to a point where
36 you couldn't manage what was going on?
37 A. Yeah. We lived on top of a shop and my tenancy was at
38 risk due to the drug use and other behaviours that were
39 happening in the home.
40
41 Q. How did that impact you?
42 A. It was very difficult. It was very difficult knowing
43 that I couldn't help her, and that she was really
44 struggling.
45
46 Q. And did it affect how - your own mental health?
47 A. Yeah, I did have a breakdown and I ended up in

1 emergency myself at that stage. I felt at that time I was
2 trying to ring every service again locally and all over
3 Victoria to try and find some help for her, and it was just
4 such a long process to go through an assessment, or get an
5 appointment or, oh well, non-engagement means no treatment.
6
7 Q. There was a point in time that the decision was made
8 that you would move back home?
9 A. Yes.
10
11 Q. And, where was your daughter to go then?
12 A. After discussing things and trying different options
13 to continue living together, we'd come to the realisation
14 that it wasn't going to work and the only option was
15 residential care again to preserve our relationship because
16 my daughter was feeling that she couldn't control her
17 behaviours and she wanted to continue those behaviours but
18 without it directly affecting and hurting me; she couldn't
19 cope with how it was hurting me, but she couldn't stop the
20 behaviours herself, so she went back into residential care.
21
22 Q. And how long did she stay there on this occasion?
23 A. About four months before she ended up back at home.
24
25 Q. There was a point in time where your daughter was
26 assaulted in a burglary ?
27 A. Yes.
28
29 Q. And she ended up calling you?
30 A. Yes.
31
32 Q. After that occurred; could you just explain what
33 happened from there?
34 A. Yeah, I got a phone call from my daughter, and she
35 said that there'd been like a run through, where people run
36 through the house and steal stuff, and she'd been assaulted
37 and had her possessions stolen and that she was feeling
38 suicidal.
39
40 Q. Did this happen in a place that she happened to be
41 staying at or?
42 A. No, this was at a friend's house.
43
44 Q. Sorry, and she contacted you?
45 A. Yes.
46
47 Q. And, what did she convey to you at that time about how

1 she was feeling?
2 A. She said that she was feeling suicidal and that she
3 would like to go to the hospital and be admitted.
4
5 Q. So, up until this point in time she still hasn't ever
6 been admitted to hospital?
7 A. Never. We've been told to hide the knives and things
8 like that, but she's been sent home.
9
10 Q. What do you mean by "hide the knives"?
11 A. Well, just for safety of self and others.
12
13 Q. And so, who would tell you to do that?
14 A. The assessment team at the hospital.
15
16 Q. And are you talking about hiding the knives at home so
17 that she can't access them?
18 A. (Witness nods.)
19
20 Q. So, did you take her to the hospital again on this
21 occasion?
22 A. Yes, I did.
23
24 Q. And, she was assessed by a child and adolescent mental
25 health worker at the hospital?
26 A. Yes.
27
28 Q. And, what happened as a result?
29 A. The worker told us that they would put a referral
30 through for a planned admission, and that we would have to
31 go home and that they would call us in the morning to
32 talk - to discuss the referral for the adolescent
33 psychiatric ward.
34
35 Q. And, what happened?
36 A. No-one called.
37
38 Q. How did you respond to that?
39 A. I called in the afternoon. I gave them all morning, I
40 think at 2 o'clock I called, and they said that they must
41 have had the wrong number. But when I asked them about the
42 referral to the psychiatric ward, they said there was no
43 referral.
44
45 Q. How did you deal with that?
46 A. I escalated - well, I made a complaint to a governing
47 board, again.

1
2 Q. And did that result in anything?
3 A. It resulted in the head clinician of that service
4 contacting me later that day, but all I did was tell my
5 story over again, and I was quite distressed by that stage,
6 and was told that I probably needed to get some sleep,
7 because that helps apparently, so yeah.
8
9 Q. And, did that result in an admission for your
10 daughter?
11 A. No. Oh, not - yeah - sorry, yes. After we had to go
12 through another assessment process.
13
14 Q. Do you want to just describe what that assessment
15 process was?
16 A. Yes. So, it wasn't that day that she was admitted
17 after I spoke to the head clinician. They had to make
18 another appointment. So, to have an appointment they
19 needed to talk to her on the phone as well, so she had to
20 talk to someone on the phone after I'd already told them
21 what was happening.
22
23 So, she'd already told them at the hospital, I'd
24 already told them at the hospital, given a full history,
25 then spoke to the head clinician, given a full history,
26 then had to speak on the phone to give a full history, and
27 then had to have an appointment down at the office to go
28 over everything again.
29
30 Q. And that appointment was with your daughter?
31 A. Yes.
32
33 Q. To take her along, I mean?
34 A. Yes, so the next day we got an appointment and I took
35 her down in the afternoon. She was incredibly dishevelled
36 by this stage, she didn't even have any shoes on or
37 anything like that, hadn't showered. And she went in and
38 spoke to a worker and there was another worker that was
39 meant to talk to me but no-one ever did and I was sitting
40 in the waiting room and my daughter came out and she was
41 incredibly distressed, and she was saying that they're not
42 going to admit her to hospital and that she's constantly
43 being rejected; every time she puts her hand up for help
44 she's being rejected.
45
46 And so, her behaviours escalated and she started to
47 smash things and become really, really distressed, and it

1 was at that point that they decided to look at a referral
2 for her.
3
4 Q. And so, was that referral made?
5 A. Yes, that referral was made and that was also after I
6 expressed to them that she was also experiencing homicidal
7 thoughts and self-harm - and harm to others.
8
9 We had to wait a really long time to find out if they
10 had a bed as well, so we sat at that office until they came
11 in and said, "You have to go home now because we're
12 closing", so then I had to take her home again.
13
14 Q. And so, when did she end up being admitted?
15 A. She was admitted that night, I got a phone call and I
16 drove her down to Melbourne.
17
18 Q. Was she in a youth facility or what kind of an
19 admission was that?
20 A. Yes, it was a youth psychiatric ward.
21
22 Q. Was she there voluntarily?
23 A. She was there voluntarily.
24
25 Q. And so, how long did she stay there for?
26 A. Two nights.
27
28 Q. What was her experience like at that time?
29 A. She doesn't remember much of it, she was highly
30 medicated with Valium and things like that. She was told
31 that she became aggressive to one of the workers, which she
32 can't remember, and she was placed in high dependency ward,
33 which is the locked ward.
34
35 Q. And so, she spent the two nights there in the locked
36 ward?
37 A. Yes, and then she said, "I can't do this any more,
38 please let me out", and so they did.
39
40 Q. And where did she go from there?
41 A. Back to residential care.
42
43 Q. And, about four months later --
44 A. Yes.
45
46 Q. -- things became difficult for your daughter again?
47 A. Yes, I got a phone call late one night. She'd been

1 self-harming and was incredibly suicidal, and came home
2 that night - the next day - she had a CAMHS worker at that
3 time but wasn't really engaging with her, and so, I called
4 the next morning and alerted them that [redacted]
5 [redacted] wants to die, and
6 the worker came and did an assessment.
7
8 When she left she called me and said that she'd spoken
9 to the psychiatrist and that they would be admitting her,
10 and it would be a sectioning if she didn't agree. Even
11 though she was saying that she wanted to go to hospital,
12 they said it would be a sectioning and, to me, I was just
13 like, well, she's agreeing to go. But what they didn't
14 tell me was that, because she was going to be sectioned she
15 would have been - she was going to be put back in the high
16 dependency ward and we didn't know that at that time.
17
18 Q. And by this time you had taken months off work?
19 A. Yes, I'd taken six months off work --
20
21 Q. To care for her.
22 A. -- when I originally lived with her, I took six months
23 unpaid leave. Actually, at that time I tried to quit my
24 job because I work in the industry and it was just too
25 much. But my boss just kept saying, "Just keep taking as
26 much leave as you want", so yeah, I had a lot of time off.
27
28 So they did say that they were going to admit her, and
29 a week later I still had her at home because they couldn't
30 find a bed anywhere in Victoria for her.
31
32 Q. So, what was going on in that week?
33 A. Oh, it was hell for my daughter. Just in bed, she
34 just - she couldn't even shower herself. She was just
35 crying all the time and telling me the deepest darkest
36 things that you couldn't ever imagine wanting to hear from
37 your child.
38
39 Q. And so, was a bed eventually found for her?
40 A. Well, after a week it became too much for her and
41 there were some outside influences that contributed to her
42 having another breakdown, panic attack, which turned into
43 another hugely dissociative episode, which to me looked
44 like a psychotic episode.
45
46 I had to get a friend to help me get her to the
47 hospital because I was too scared to drive her, I thought

1 she was going to pull me off the road. We made it to the
2 hospital and her presentation was so bad that they just
3 ushered us straight into a, like, a private room, gave her
4 an antipsychotic until that kicked in, and then - this time
5 it didn't actually take too long to get a mental health
6 worker.
7
8 I said, "If you're going to send her home, you need to
9 make sure you're giving us some very heavy sedatives",
10 because there was risk of harm to others and herself so
11 high at that stage that I was imploring the hospital, and
12 they sectioned her into the emergency room. They had no
13 beds in the hospital, so she was sectioned in emergency for
14 the night.
15
16 Q. Sorry, so you said for the night. Did she stay in
17 that emergency department for longer than that?
18 A. She was in there until midday the next day.
19
20 Q. Where did she get taken from there?
21 A. To the paediatric ward.
22
23 Q. Was that a specialist mental health ward?
24 A. No.
25
26 Q. What about from there, was she moved elsewhere?
27 A. 8 o'clock that night we found out there was a bed and
28 she was ambulanced down to Melbourne for - the same
29 psychiatric ward that she had been to last time.
30
31 Q. Was she then put in the high dependence ward again?
32 A. Taken straight to the high dependency, and she wasn't
33 aware that that would be the case.
34
35 Q. And you weren't aware either?
36 A. (Witness shakes head.)
37
38 Q. The next morning she rang you and she was in tears?
39 A. Yes.
40
41 Q. What did she tell you?
42 A. She said she'd been put in high dependency and she was
43 having flashbacks of how it happened last time. So, she
44 had memories coming back of them laughing at her when they
45 were, you know, putting her in there and the way - what
46 they were saying to her and treating her was pretty
47 appalling.

1
2 Q. How long did she spend in the high dependency ward at
3 that time?
4 A. Nearly a week, and she was the only person in there,
5 there was no-one else. So, it was just two workers and
6 her, and that's it, and nothing to do. They had a TV in
7 there that you can barely hear, because it's behind a big
8 plastic thing, and you can only watch G-rated stuff on the
9 TV.
10
11 So, she dragged her - they're sort of cells off the
12 room and she just dragged out all the mattresses and made a
13 little nest for herself and I would spend as much time
14 every day with her just laying there with her and trying to
15 get her through.
16
17 Q. Was she receiving medication during this stage?
18 A. She was highly medicated.
19
20 Q. You ended up having a meeting with the staff and your
21 daughter's care team, who were based at that hospital?
22 A. Yes - well, the care team weren't based at the
23 hospital.
24
25 Q. Sorry.
26 A. But the - yeah.
27
28 Q. But there were hospital staff there?
29 A. Yes.
30
31 Q. There were members of her care team there and you
32 attended?
33 A. Yes.
34
35 Q. What was the result of all that?
36 A. Basically they gave her another diagnosis. I wasn't
37 directly spoken to at that meeting and that made me feel
38 very distressed and worthless as a parent. And it was very
39 cold and very clinical, and I had to actually walk out of
40 that meeting because I couldn't - I just couldn't believe
41 it. And they were just saying that, it's not therapeutic
42 for her to be there and they'd be releasing her soon.
43
44 Q. And, did they?
45 A. Yes.
46
47 Q. And so how long all up then was that stay?

1 A. Probably - she was there for about a week - I don't
2 know the exact amount of days, but it was around that,
3 yeah.
4
5 Q. And so, can you just describe the point in time where
6 you're leaving the high dependency unit with your daughter
7 and what that was like?
8 A. Yeah, so the morning that they said they were going to
9 exit her or discharge her, we could see a build-up of
10 people in the office, and they said at 10 o'clock that she
11 could leave, and she was just so desperate to get out of
12 there that 10 o'clock came and left and she started
13 becoming incredibly distressed and irritable, and so I was
14 trying to manage her. But no-one was telling us what was
15 going on but we could see in the office all of these people
16 standing around, they had these looks on their faces and we
17 didn't know what was going on.
18
19 She tried to attack one of the workers because she was
20 just so, like a caged - she felt like a caged animal, it
21 was like a caged animal. She said, "Get me out of here,
22 you said 10 o'clock", it was now coming to 11 o'clock and
23 we weren't being told anything, she was just being held
24 there and she wanted to get out.
25
26 We got escorted out the back way by two security
27 guards. My daughter could barely walk. I had to hold her
28 and she was shaking and muttering and just an absolute
29 mess. It was horrible. I couldn't believe that this was
30 happening, and I was walking through the hospital with her
31 like that. And, as soon as we got to the doors, the
32 security guards left and I was left with this child.
33
34 Q. And she'd been given medication before she left?
35 A. Yeah, they gave her Valium but it hadn't kicked in
36 yet.
37
38 Q. And so, did you have to wait for the Valium to kick in
39 before you could leave?
40 A. Yeah, so when we got out to the front of the hospital
41 she was walking really fast off on me and when I caught up
42 to her, we had - another two members of her care team were
43 there, but my daughter couldn't engage with them, and I was
44 trying to catch up to her and she was saying, "Mum, I want
45 to throw myself in front of the traffic", and so, I had to
46 manage that situation and then sit with her. She just sort
47 of fell and sat and cried, and talked about wanting to die

1 under a tree on the street out the front of this hospital,
2 and I had to wait for the Valium to kick in before I could
3 get her in the car.
4
5 Q. And your daughter then ended up staying with you for
6 six months after that?
7 A. Yes.
8
9 Q. And, how was she during that time?
10 A. It was like warehousing a person. It was - she had no
11 life. She had no contact with friends. She was in bed
12 most of every day. She had intrusive thoughts during that
13 time, a lot. She was on antipsychotic medicine three times
14 a day which made her put weight on which made her feel even
15 worse about herself. In those dark hours of the night that
16 no-one else is aware of I had to hold my child, crying most
17 of the time.
18
19 Q. And you ended up having to go back to work?
20 A. Yeah, I had to go back to work part-time.
21
22 Q. After that there was a time when your daughter went to
23 a detox clinic?
24 A. Yeah, so the care team had organised for her to go to
25 a detox, mainly for her to get some social interaction and
26 have a break from - at that time she was smoking a minimal
27 amount of marijuana, to have a break from that, and also
28 for some respite for myself, but there was no option for
29 rehab at that time, so basically we were just waiting for
30 rehab but they said that she could go to detox, with no
31 outcome from that, and so she did that twice.
32
33 Q. What was the length of those stays?
34 A. The first one was two weeks and the second one was a
35 week which led straight to rehab. But we had to wait a
36 significant amount of time for her to - for the referral to
37 go through and then the wait list - to be put on the wait
38 list for rehab.
39
40 Q. There was a time that your daughter said she wanted to
41 move to Melbourne?
42 A. Yes.
43
44 Q. And to try and live in a facility that could help her
45 manage her mental health?
46 A. Yes.
47

1 Q. And be with other teenagers?
2 A. Yes.
3
4 Q. So, did that happen?
5 A. No.
6
7 Q. What was available to her in that way? Was there
8 anything she could - anywhere she could go?
9 A. No, because the care team were working towards a
10 certain facility in Melbourne for her, and she was taken
11 down to the facility and met the people there and at that
12 time she was told that there were beds available but, due
13 to the way that this certain facility works, they only have
14 a monthly panel, so it sits once a month, the panel.
15
16 The referral went in probably the day after the panel
17 sat for that month, so we had to wait for another month.
18 And we had really high hopes, we were pinning everything on
19 that: the social isolation, the depression, because she had
20 such social anxiety and so much trauma in the town that we
21 lived in, she couldn't access anything there, so Melbourne
22 was her - was where she wanted to go so she could start
23 living a life. And yeah, so we had our hopes and dreams
24 pinned on this and we felt really positive about it, and we
25 received a call on the day, the panel saying that she had
26 not been accepted but were not given any information as to
27 why.
28
29 Q. And that led to a pretty significant impact on you?
30 A. Yeah.
31
32 Q. Let alone your daughter.
33 A. I had another breakdown at that point. I was so
34 worried my daughter was going to kill herself.
35
36 Q. So, you had to make other plans?
37 A. (Witness nods head.)
38
39 Q. And so, what did you do?
40 A. Well, with the help of her care team it was decided
41 that, to access Melbourne services due to catchment area
42 issues, that she would have to move to live with her dad in
43 [REDACTED], which she didn't want to do. It was the only
44 option, she had no other option.
45
46 Q. And so, she moved back with her father?
47 A. Yes.

1
2 Q. And she started attending school again?
3 A. She tried. She took herself off her medication when
4 she lived with her father and we didn't know, and the
5 weekend before she was due to attend school the anxiety and
6 everything, she started having incredible paranoia and sort
7 of delusional thoughts, and the morning of school had tried
8 desperately - it was an incredibly arduous situation for
9 her, incredibly distressing.
10
11 She did make it to school through sheer determination
12 of wanting so badly to have a life and education and be
13 around people, but by the time she made it to school she
14 couldn't even stay in the class, and thank God her worker -
15 I had alerted her worker and she'd driven down and met her
16 and her worker at that time made an assessment that she
17 needed to go to hospital again.
18
19 Q. And so, she ended up in an emergency department in a
20 hospital in Melbourne?
21 A. Yes.
22
23 Q. And, was she admitted again at that stage?
24 A. Once again, she told her story, and it was from what I
25 heard - and I know - so distressing that it actually made
26 one of the workers cry in there. And they said, "Yes, we
27 believe you need to be admitted, but you'll be put straight
28 in the high dependency ward because you've been violent in
29 the past", and so, my daughter had to decline because that
30 was a source of trauma for her, being put in the high
31 dependency ward.
32
33 Q. Given what she'd experienced there?
34 A. Yes.
35
36 Q. And you ended up staying in a hotel with her?
37 A. Yes, stayed in a hotel that night with her.
38
39 Q. And went to a GP the following day?
40 A. Yeah, took her to a GP to get her back on her
41 medication.
42
43 Q. And so, what did you do after that in terms of trying
44 to get help for her?
45 A. Well, it was recognised that she would need somewhere
46 to stabilise for her medication, so with the help of the
47 care team I hired out a place in [REDACTED] near her

1 school, to stay with her, to stabilise her on her
2 medication and do a graded approach to school for her
3 during that time and see if we could do it like that
4 because being at her dad's wasn't an emotionally supportive
5 place for her to be able to get back on her medication and
6 stabilise.
7
8 Q. And so, how did that go in terms of that plan?
9 A. Not very well. My daughter ended up incredibly
10 suicidal again. So, after she went to the hospital and was
11 told that, yes, they believed she should be admitted but
12 you will be in the high dependency ward, the care team and
13 myself had made numerous calls to a different hospital
14 because she was now in a different catchment area and could
15 access a different hospital and I was told that there was
16 no alert on their file and if she presented at their
17 hospital she would be assessed as is, not - because there
18 is an alert on her system.
19
20 So, during that time she did become incredibly
21 suicidal again, and I had to stop her from trying to get
22 out of the house at one stage because she wanted to go and
23 jump in front of the trams and trains and things, and she
24 was talking more about wanting to jump in front of trains
25 at that time.
26
27 And, after an incredibly distressing day of trying to
28 manage her, once I got some medication into her and she
29 slept I started making a million phone calls to every
30 service that I could think of, and I was highly distressed
31 at that time too, so I called that hospital. I called the
32 number that they gave me to call to get a, what they call a
33 72-hour appointment.
34
35 Q. Okay, and that was like a triage number?
36 A. Yes. So, I was told to call that number. I called
37 that number, had to tell them everything again, all the
38 complexities of the situation, and I spoke to the head
39 clinician there and he said he could get her a 72-hour
40 appointment but it wouldn't be that day, and that
41 potentially if there was a psychiatrist involved that was
42 the only way that they could not go through the ER. And he
43 said that he would see if there was a bed available; that
44 was my memory of the conversation, and that he would call
45 me back later that day.
46
47 Q. And so, do you say that's your memory of the

1 conversation because he didn't call?
2 A. He didn't call, and it was not reflected in the notes
3 that that was what was meant to happen.
4
5 Q. So, what happened for Natasha's care after that?
6 A. I ended up having to take her back home. I had
7 actually also had - I didn't feel like I could cope on my
8 own in that place at that time on my own, and I also had
9 training to attend that would - that was relevant to the
10 situation of what was happening for my child that I wanted
11 to attend as well, so it was trauma, childhood trauma
12 training and things like that. So I had to try and weigh
13 up, do I stay down here and wait, do I go home and get the
14 support that I need, do I - I had so many things going on
15 in my mind, so I ended up taking her home to get some
16 support for all of us. And by that stage the GP had
17 prescribed to me Valium to give her, knowing that the psych
18 ward was not an option for her, so I would essentially
19 become her psych ward.
20
21 Q. And so, you've talked about the training that you
22 wanted to attend. There was a point in time where your
23 daughter was able to get some specific care that was
24 directed towards the trauma that she had experienced.
25 A. Yes.
26
27 Q. How did she find that, or how did you find that?
28 A. There was a service organisation due to her being in
29 residential care that we were part of.
30
31 Q. Yes.
32 A. And there was a specific program that had been
33 designed by one of the psychologists that works in that
34 organisation that's based on relationship, with an
35 underpinning of trauma informed care, yeah.
36
37 Q. And so, how did that assist your daughter, if it did?
38 A. Well, she engages with the program and it's the only
39 program, and they know our story and they're staunch
40 advocates for my daughter. And, the program is based on
41 understanding how trauma affects relationship, and so, she
42 has a psychologist, I have a psychologist and she has a
43 trauma informed case manager that just works on
44 relationship.
45
46 Q. And so, to this day, are you both supported by that
47 service?

1 A. Yes.
2
3 Q. Can I ask you about some specific problems that you
4 perceive with the system that you've encountered; the
5 Commission have had the opportunity to hear about many of
6 them. But in particular, is one of the things you've
7 encountered, putting your hand up for help and not
8 receiving it?
9 A. Yes. Myself and my daughter have put our hand up for
10 help so many times, and we have not received it, and in
11 terms of accessing contained therapy - well, you know, a
12 therapeutic place in a contained environment, that's just
13 never been an option for her which is what my daughter has
14 identified that she needs.
15
16 So, when she's feeling unsafe, like she could hurt
17 herself or someone else, she has wanted to be contained
18 and, due to her instability and when she says she wants to
19 go, she can just be released. And, she's never been given
20 an option of being able to say - to not have the
21 opportunity to flee in times that it gets difficult, and so
22 that's what's happened. That's what's happened in rehab
23 twice now, that's what happens in the psychiatric ward, is
24 that it gets too much for her, she cannot cope and she's
25 just allowed to go and she's just a child, so she - and
26 then just goes and actively traumatises herself in the
27 community again.
28
29 Q. One of the things that you've said in your statement
30 is that you feel like as a mother and a carer, "I'm only
31 seen by acute mental health services in complete crisis,
32 and then I'm assessed as driven by crisis and overly
33 emotional"?
34 A. Yes. I feel like I've been assessed as someone who's
35 mentally unwell myself and unstable myself, because I
36 manage it in the home until it gets to a point that I can't
37 manage any more, but then, you are only viewed as someone
38 who is emotionally unstable yourself because you're only
39 seen in those times and notes are taken.
40
41 You might be rambling, you might not have slept, you
42 might be looking dishevelled yourself, you might be so
43 incredibly frustrated with the years of systematic failure
44 that you might present in a way that you will be assessed
45 as someone that is unstable yourself, which is - it's
46 inaccurate, and it's - actually, those assessments have had
47 a huge impact on my life and that's probably another Royal

1 Commission that needs to be done there, for what the
2 outcome has been for what's happened with that.
3
4 Q. You've experienced feelings of being judged and
5 misunderstood?
6 A. Yes. Yes, to the detriment of decisions that are
7 being made for my child in terms of me being able to care
8 for her.
9
10 Q. One of the things that you've talked about in your
11 evidence today is having to tell your story time and time
12 again, and ultimately that's led, for you, to a distrust of
13 the system.
14 A. Yes.
15
16 Q. And for your daughter.
17 A. Oh, absolutely.
18
19 Q. Can I just ask you two further questions. One thing
20 that arose in your statement is the idea of early
21 intervention, particularly with family involvement. Do you
22 want to say something specifically about that?
23 A. Yes. In terms of early intervention, from what would
24 have been really beneficial to change the trajectory of my
25 daughter's life and my life would have been a focus on
26 parent support when she was much younger.
27
28 I have the benefit of working in the industry and
29 delivering these programs to parents and seeing the
30 incredibly positive impact it has on relationship, and I
31 feel, if I had have received the support and the training
32 to respond therapeutically to my daughter when she was
33 experiencing anxiety and fear and behavioural issues, that
34 we may not have ever had to have ended up at the hospital;
35 that I would have been given the skills to be able to
36 manage that in the home myself. I feel very strongly about
37 that, that parent support and education around that.
38
39 MS COGHLAN: Thank you, Melanie. Chair, do the
40 Commissioners have any questions?
41
42 CHAIR: No. Thank you very much for sharing your
43 reflections with us.
44
45 MS COGHLAN: Thank you. May she be excused, please?
46
47 CHAIR: Yes, you may.

1
2 **<THE WITNESS WITHDREW**
3
4 MS COGHLAN: Can I just enquire whether the Commissioners
5 would like a break now?
6
7 CHAIR: No, we're fine to go on to the next witness, thank
8 you.
9
10 MS COGHLAN: That's fine.
11
12 MS NICHOLS: We'll just wait for the live stream to cut
13 in.
14
15 (Live stream connected.)
16
17 MS NICHOLS: Commissioners, the next witness is Professor
18 Helen Herrman. I call her now.
19
20 **<HELEN EDITH HERRMAN, sworn: [3.00pm]**
21
22 MS NICHOLS: Q. Professor Herrman, have you prepared a
23 witness statement, with the help of the Royal Commission,
24 in relation to your opinions concerning the questions we've
25 asked you?
26 A. I have.
27
28 Q. I tender the statement. [WIT.0001.0020.0001]
29 Professor Herrman, are you the President of the World
30 Psychiatric Association?
31 A. I am.
32
33 Q. Among other appointments, are you a Director of the
34 World Health Organisation Collaborating Centre in
35 Melbourne?
36 A. I am.
37
38 Q. Are you a Practitioner Fellow of the Australian
39 National Health and Medical Research Council?
40 A. Yes.
41
42 Q. Has your scholarship concentrated, among other things,
43 on psychiatric epidemiology?
44 A. Yes.
45
46 Q. Are you head of vulnerable and disengaged youth
47 research at Orygen?

1 A. I am.
2
3 Q. Has part of your research been directed to improving
4 the mental health of young people in and out of home care?
5 A. Correct.
6
7 Q. Can I start by asking you this: having worked in the
8 field of public health for a number of decades, what does
9 the expression "public health" mean and, in broad terms,
10 what activities does it encompass?
11 A. Well, we think of public health as the organised and
12 collective activities that we might undertake as a state or
13 a community to improve health and to reduce the
14 inequalities in health and this is an academic discipline
15 and a practice.
16
17 It covers a number of areas which are of equal
18 importance. We've heard a very moving story about the
19 importance of care when it's needed, and equally important
20 is the prevention of ill-health at various stages. It can
21 be prevented - of course, not all forms of ill-health can
22 be prevented in mental health as in general health, but it
23 can be prevented in a whole range of different ways we can
24 no doubt consider further.
25
26 As well as, in addition to both those things, the
27 promotion of mental health which is important in terms of
28 understanding that good mental health is a value that we
29 can promote and use as well.
30
31 Q. And so it's right, isn't it, that the objectives of
32 public health are much broader than the provision of
33 clinical services to treat illness?
34 A. Yes, as I said, those are a very important component
35 but is one part of it.
36
37 Q. Has it always been accepted that mental health
38 outcomes can and should be improved through public health
39 actions?
40 A. Yes, that's been a conviction and an area of my work
41 for quite a long time.
42
43 Q. I understand that you are convicted about that, but
44 has it taken some time for mental health to be understood
45 as an integral part of public health?
46 A. Yes, I think it's something that is growing now, but
47 for a long time the idea that the state of mental health in

1 a person or in a community could be changed through the
2 things that we do as a community has not been part of the
3 activities or part - not really been part of our clinical
4 training, not been part of the way that governments plan
5 and practice or manage services.
6
7 Q. And, accepting that it is now, what are your views
8 about why it was that mental health was seen as something
9 separate from public health?
10 A. Perhaps we go back to two things: one is, thinking
11 about the origins of public health, which was the origins
12 of public health in preventing infectious diseases,
13 beginning with cholera two centuries ago, by looking at
14 where the - how the people were distributed in terms of
15 water distribution in the city and dealing with that.
16 Providing sewers, preventing overcrowding to prevent
17 tuberculosus, and that gradually was taken up in terms of
18 more chronic and long-standing or so-called
19 non-communicable diseases such as heart disease and cancer.
20
21 More latterly - well, at that point too for a long
22 time the whole question of whether mental health was part
23 of health was in question. We had long-standing views that
24 mental and physical health are separate from one another;
25 the Cartesian view of human health, in a sense. But
26 there's been a growing body of evidence and understanding
27 that I think many in this room would now share, that mental
28 and physical health are closely interacting and need to be
29 considered together in the health system as well as more
30 broadly.
31
32 Q. Yes. For example, at the level of the World Health
33 Organisation, is mental health now treated in the same way
34 as other non-communicable diseases for the purposes of
35 public health goals?
36 A. Yes, well, this is a very new development; that for
37 the first time in the World Health Organisation's high
38 level Commission on non-communicable diseases that reported
39 to the United Nations General Assembly last
40 September, September 2018, it was the first time that
41 mental health was mentioned explicitly. There's now a
42 Commission in fact on non-communicable diseases including
43 mental health for a range of reasons that relate to that
44 interaction.
45
46 Q. Just so we can be clear, what are the other groups of
47 non-communicable diseases?

1 A. There are several major groups, one of them would be
2 what they call cardiovascular disease, so diseases
3 resulting from problems with the heart and the blood
4 vessels that might include stroke and heart attacks;
5 cancer, diabetes and respiratory diseases of various types.
6
7 Q. Can I ask you now about mental health promotion. In
8 your view, is health promotion the same thing as preventing
9 mental illness?
10 A. Well, it's - conceptually they're different. The
11 activities overlap, but when we think of health promotion,
12 I think it's, typically think about how to improve mental
13 health. The analogy being, if we improve physical health,
14 we might go and exercise or diet, and provide as a
15 community the facilities for doing that.
16
17 In terms of mental health, we might be more connected
18 socially and we might be more engaged in education and such
19 like, and how do we provide the community facilities to
20 promote and protect mental health and allow people to make
21 those decisions.
22
23 In terms of prevention, it's preventing mental
24 ill-health. Now, mental health and mental ill-health are
25 related but not completely opposite, and so that, by
26 promoting health we are preventing a number of the risk
27 factors for mental ill-health, but prevention of mental
28 ill-health can be more specifically designed to prevent the
29 downstream consequences of things like violence and
30 maltreatment of children, neglect of children, difficulties
31 with parenting, bullying at school and poor conditions in
32 the workplace.
33
34 They may also include more activities closer to the
35 person than within the health service that may prevent some
36 conditions such as depression, although not all types of
37 mental ill-health.
38
39 Q. And are those factors usually grouped together and
40 called determinants of mental illness?
41 A. Yes, it's now the - in common with the rest of health,
42 there's a large focus on the social determinants of health.
43
44 Q. And, what are some of the important social
45 determinants?
46 A. Well, for all types of health, including mental
47 health, relative social disadvantage - so, poverty, and

1 being worse off than the people around you, poor social
2 status, this is a powerful factor.
3
4 The second is gender discrimination, so that, the
5 place of women in certain communities and even more subtle
6 forms of discrimination.
7
8 The third is violence: violence in the family,
9 violence in the community. Another factor is in fact
10 physical ill-health in terms of mental ill-health.
11
12 Q. Each of those things you've mentioned, are they,
13 according to well-established literature, determinants for
14 mental illness?
15 A. For?
16
17 Q. Mental illness?
18 A. Yes.
19
20 Q. Are there some determinants of mental illness that are
21 particular to the individual?
22 A. Well, every - again, there's a close analogy with
23 health, that for any individual there are many influences
24 on a state of health or a state of ill-health. And,
25 although the commonly used term is "social determinants",
26 in fact these are influences on health, so there are always
27 instances where people come through major difficulties, for
28 instance severe trauma in childhood and are not depressed
29 in adulthood. But it's a question of risk. So, despite
30 the term, it's really a sense of, what are the major
31 influences, both biological within the person, their own
32 psychological processes, and the social influences.
33
34 Q. So, is "influences" perhaps a better term because it
35 recognises risk rather than inevitability?
36 A. Yes, correct.
37
38 Q. Can I turn now and ask you about prevention. Can I
39 just ask you this: does primary prevention in the
40 literature refer to preventing the onset of illness?
41 A. Correct.
42
43 Q. Does secondary prevention mean reducing the duration
44 and associated disability caused by illness by providing
45 early treatment?
46 A. Correct.
47

1 Q. Is there a difference between early intervention and
2 early treatment or are they the same thing?
3 A. The way that I understand that term being used,
4 they're very similar, yes.
5
6 Q. Alright. And what is tertiary intervention?
7 A. Well that, in a way, is what happens in the clinical
8 services and beyond as well; the supports for
9 rehabilitation and recovery that may occur with supports
10 from outside the health system as well, hopefully well
11 integrated.
12
13 Q. Is there a sense in which tertiary intervention is
14 after the event?
15 A. Yes, that's right. And, sometimes of course the
16 activities are not that different if they involve a person
17 becoming more socially connected or having a sense of
18 self-esteem and an ability to find a job, support for that
19 that they wish to undertake.
20
21 Q. You say in your statement that you've given to the
22 Commission, in your view:
23
24 "The importance of mental health promotion
25 in the context of public health cannot be
26 overstated."
27
28 We'll talk about that in some detail, but can I just
29 ask you to explain to the Commissioners why you hold that
30 view?
31 A. Well, I think it's because of the fact that we have
32 had a view different in mental health from the rest of
33 health and we can see the difference it's made in the rest
34 of health. For instance, we could say that in the 1950s,
35 60s, 70s there were rising rates of - rapidly rising rates
36 of heart disease in populations in the wealthy world: in
37 Europe, the United States, Australia. And people began to
38 recognise that exercise and diet might be important and
39 began to put these measures in place.
40
41 At the time there was a lot of competition between the
42 clinical services and these preventive measures, but over
43 time people recognised that they were each important, and
44 in fact the public health measures, stopping smoking,
45 increasing the attention to what people ate and the way
46 they exercised, changed the pattern of disease in many of
47 those communities. At the same time many people still

1 continued to have ill-health, that wasn't going to
2 disappear.
3
4 Q. Do you have a view in the general health context about
5 some of the important things that lead to the lessening of
6 competition between different clinical streams?
7 A. Ah, well, I think that's a very important thought. I
8 think it's to do with awareness to a large degree, that
9 when we have, first of all, awareness in the general
10 community, then that pushes everybody to think about what
11 sort of measures are needed to support this community
12 awareness.
13
14 So, if people are understanding the fact that good
15 mental health brings many benefits at the individual and
16 community level, and that ill-health is nothing to do with
17 blame or weakness but it's something that happens for this
18 multitude of reasons in terms of any one person's
19 experience, everybody's better off, the person, the family,
20 the community, if adequate supports are in place. We've
21 heard a very, again, moving story about the difficulties
22 that arise when they're not.
23
24 Q. Can I ask you, before we investigate this a little bit
25 further, to tell the Commissioners - really to tell all of
26 us, because I think the Commissioners probably know
27 already - what are the principal classifications or types
28 of mental disorder?
29 A. I suppose we begin with the idea that there are common
30 mental disorders and much less common ones. And, with the
31 idea that over time what has really affected the public
32 understanding and governmental understanding is the
33 so-called burden that these conditions produce in terms
34 of years of disability lost in terms - rather than just
35 counting numbers.
36
37 But the common mental disorders, in which depression
38 and anxiety are the major ones, are quite - of different
39 levels of severity are quite common in the community. It's
40 said that up to maybe 20 per cent of people in any
41 community will experience one of those conditions in their
42 lifetime.
43
44 Q. So, this is depression and anxiety?
45 A. Yes.
46
47 Q. And they're grouped together?

1 A. Yes.
2
3 Q. Alright. If we take that as a large prevalence
4 disorder --
5 A. Yes, that's right, high prevalence.
6
7 Q. High prevalence, I beg your pardon, and perhaps moving
8 towards the less prevalence disorders, what is next?
9 A. Yes, well then we might be thinking broadly about
10 conditions, schizophrenia and related conditions that come
11 under the heading of psychoses. Some of the mood disorders
12 called bipolar disorders might be linked with that group as
13 well, each occurring - maybe one in a hundred of the
14 population may be affected by these conditions.
15
16 Q. So, with psychosis, is it appropriate to differentiate
17 between schizophrenia, bipolar disorder and other forms of
18 psychosis?
19 A. It is, I believe, yes.
20
21 Q. Are they the main classifications?
22 A. That would be, broadly speaking, correct as I
23 understand.
24
25 Q. Do substance abuse disorders fall into their own
26 category?
27 A. Yes. So, that we could say substance abuse disorders
28 are also quite common, particularly alcohol use disorders
29 in this community and in many communities, and the use of
30 other substances, called illicit substances, is also a
31 problem, and the use of prescription opiates and other
32 prescribed medications in harmful ways is also important.
33
34 Q. Where do personality disorders fit in that
35 classification?
36 A. Well, I suppose, if we're talking about a general
37 public understanding of mental disorders we might have a
38 category we call "other" and we might include personality
39 disorders; we might include eating disorders and a range of
40 other conditions, all of which are - they're not to
41 minimise them by putting them in this "other" category.
42 And, as you've heard, somebody who may be diagnosed as
43 having a borderline personality disorder could have a very
44 severe and difficult experience.
45
46 Q. Is there a separately understood category of disorders
47 of childhood?

1 A. Yes. Generally, that might include the early onset of
2 a number of the ones we've already mentioned as well as a
3 range of learning and development disorders and
4 disabilities.
5
6 Q. With that background, professor, can I ask you about
7 the evidence base for the effectiveness of early
8 intervention and prevention. Can I go to something you
9 have said in your statement which is that:
10
11 "Experience has shown that many adverse
12 outcomes can be avoided with early
13 recognition and treatment or with
14 appropriate and sustained support for
15 people and families living with long-term
16 illness."
17
18 So, just focusing on that statement for a moment, when
19 you say "adverse outcomes", what's included in preventing
20 adverse outcomes?
21 A. I mention two things in that statement: one is the
22 early intervention and the other is sustained support.
23
24 Q. Yes.
25 A. And in each case it's concerned with relieving the
26 suffering of the person.
27
28 Q. Yes.
29 A. And hence, the suffering and distress of those around
30 them as well, so that, we avoid the adverse outcome of
31 prolonged suffering. And then you might have the concept
32 of the associated disabilities, the person who's not able
33 to mix with other people, not able to enjoy life, who may
34 be terrified if it's a psychotic disorder by the
35 experiences and unable to participate in a range of other
36 activities.
37
38 Which leads to the next stage of, if you like,
39 disabilities of loss of education, loss of social
40 connections, loss of opportunity and vocation, loss of
41 family life or the opportunity to develop a family if it's
42 a young person.
43
44 Q. Is it implicit in that analysis that, with some types
45 of experiences of mental illness they may be prevented, but
46 with others the experience itself and the duration might be
47 minimised?

1 A. Sorry?
2
3 Q. Is it implicit in your analysis that for some types of
4 mental illness or particular experiences of mental illness
5 with certain people, prevention may occur; but with others
6 preventing adverse outcomes is about changing the course of
7 the disease or minimising its effect on a person?
8 A. Yes, absolutely. I think where that second part of
9 the sentence comes in, that although for instance with
10 schizophrenia and related psychoses, we're not clear about
11 what are all the antecedents and the possibilities of
12 specific prevention, but we are aware that it's possible to
13 modify, work with the person, support them and their
14 families and modify the outcomes in many cases, many
15 situations, to support the recovery, support the belief in
16 themselves during that recovery process.
17
18 Q. Alright. I'll ask you a bit more about that shortly.
19 You've said in your statement though that:
20
21 "Most people with potentially remediable
22 disorders are not treated. There's a
23 continuing failure to recognise and treat
24 mental illness, particularly anxiety and
25 depression in people attending general
26 practitioners or general hospitals. About
27 20 per cent of these patients suffer from
28 well defined mental illnesses often
29 associated with physical illness."
30
31 Is it your view that the failure to treat well defined
32 mental illness particularly relates to anxiety and
33 depression?
34 A. I think that's the most - they are the prevalent
35 conditions and that's, I think, one of the major problems
36 and particularly in certain population groups, including
37 women who are pregnant and soon after birth.
38
39 Q. You go on to say that:
40
41 "It's tempting for services, governments
42 and non-government organisations in the
43 face of overwhelming distress and
44 disability to concentrate almost
45 exclusively on those well-established
46 illnesses."
47

1 What is it that makes that the overwhelming
2 temptation?
3 A. I think it's partly the sense that there's - we're not
4 coping with that demand and there is a very high demand, as
5 we know, for help, or a high request; it's using the demand
6 in the technical sense. But that, so how can we be
7 diverting resources to things that may or may not work in
8 the longer term?
9
10 And I think that's where, as a community system, we're
11 working across health, we're working across education,
12 welfare, family support, workplace, relations and so on,
13 that it's - just as we've done for heart health and smoking
14 control, we have a huge job to do to support people and
15 families to be aware of what's going to be helpful and to
16 assist them when they do seek help as well.
17
18
19 Q. And so, it's right, isn't it, that what you're really
20 saying is, you need both, investment in prevention, early
21 intervention, as well as treatment for chronic conditions
22 and acute conditions?
23 A. That's right, yes.
24
25 Q. You say in your statement that:
26
27 "Early case identification and intensive
28 treatment of first episode illness was
29 first proposed as a preventive strategy for
30 the psychotic illnesses in the 1990s."
31
32 So just focusing back at that period of time, that
33 early identification of the role of early intervention, was
34 that limited to the psychotic illnesses?
35 A. Well, the idea began with the psychotic illnesses,
36 yes, and I would point out that we're talking there about
37 secondary prevention, about changing the course of illness
38 and reducing the risk of associated
39 complications/disabilities.
40
41 Q. So sticking with that idea, going back to the
42 classification of mental disorders that we discussed
43 earlier, is the evidence base for early intervention in
44 psychotic illnesses the same in relation to schizophrenia
45 as it is for other disorders?
46 A. Well, it's - there's been a lot more study most
47 specifically of the early intervention in psychotic

1 disorders. There's a growing realisation that the same
2 thing is likely to apply for other conditions, but much
3 less study specifically of this point.
4
5 Q. Alright. Perhaps to get a little bit clearer about
6 that. If we can speak about the present evidence base for
7 early intervention in psychotic illnesses other than
8 schizophrenia. Where is that up to?
9 A. Oh, I'm sorry if I misunderstood your question a
10 little before, but I wouldn't be differentiating
11 schizophrenia and the other psychoses in the sense that,
12 when these conditions are first identified it's often not
13 clear what the exact diagnosis is: whether it's
14 schizophrenia or another psychotic condition that might
15 have a different outlook; there are so-called acute
16 psychoses or schizoaffective disorders that are a mix of
17 mood and psychotic disorders. There might even be a form
18 of mood disorder, bipolar disorder.
19
20 So, many of the studies have related to early
21 intervention and psychosis rather than in one specific
22 identified mental disorder.
23
24 Q. I see, yes. Accepting that to be the case, what do
25 you say about the current state of the evidence in relation
26 to early intervention? Do you say it is established in
27 relation to secondary prevention or primary prevention?
28 A. Secondary prevention for the - by using that term
29 "early intervention", yes.
30
31 Q. What about prevention?
32 A. Prevention for the psychoses?
33
34 Q. Yes.
35 A. Yes, this is a field of intense interest, and there
36 have been studies of so-called high risk groups of people
37 whose parents may have had psychotic disorders; there have
38 been studies of population groups and studies of young
39 people in particular who may present with a range of
40 experiences that are psychotic in nature but perhaps don't
41 add up as a whole to a current diagnosis, and those studies
42 are ongoing and it's important to understand where that may
43 lead, but it's different from what I've been referring to
44 as early intervention, and for these more rare conditions
45 it stands aside in a way from the broader statements about
46 prevention of disorders.
47

1 Although many of the - what we may come to - the
2 upstream determinants or influences on mental health, such
3 as child maltreatment, overall there appears to be a higher
4 rate of all conditions, including psychoses, in people with
5 reported experiences of that type compared with the rest of
6 the population, but the mechanisms and pathways are not
7 clear.
8
9 Q. Yes. So, would you say there is a good evidence base
10 for dealing with what you have called the influences and
11 what other people might call determinants in relation to
12 probably all forms of mental illness?
13 A. The?
14
15 Q. All forms of mental illness?
16 A. Yes.
17
18 Q. And when you come to primary prevention, the evidence
19 is limited when it comes to the psychotic disorders; is
20 that a fair statement?
21 A. Yes, that's right. I mean, we understand that some of
22 these broader - we know that for some reason that people
23 don't fully understand psychotic disorders are more common
24 in people who have grown up in cities, and we believe it's
25 more common in people who are second generation immigrants
26 or people who are in minority groups in a community, but we
27 don't understand the mechanisms and how exactly to prevent
28 that.
29
30 Q. When it comes to secondary prevention, is it the case
31 that there is good evidence that that is effective?
32 A. Well, yes. We now have good evidence that, at least
33 for the episode of illness, this is very effective.
34
35 Q. Yes. And, is there a question about the effectiveness
36 of secondary prevention and its relationship to the
37 duration of treatment?
38 A. Well, the duration of treatment has - you mean, in
39 terms of the evidence, it extends up to about two years of
40 treatment. So that, when early intervention is begun and
41 continued for two years. There's limited study beyond that
42 and we don't yet know what this means for the further
43 course of the illness over the next 30 years, although we
44 can anticipate that with preventing to some extent the
45 accumulation of disabilities of the type we've described,
46 that this will mitigate or change the course, but that is
47 for the future.

1
2 I think it's also very important to recognise that the
3 change of outlook in the episode of illness is very
4 important, and also, that we're undertaking this prevention
5 for that - these early interventions for this reason rather
6 than from necessarily relieving what may be seen as the
7 burden on services in the longer term; we just don't know
8 that yet.
9
10 Q. Yes, and so, are you saying that what does happen with
11 intervention, whether or not the illness is prevented, is
12 that the person suffering it is benefitted?
13 A. Yes. It would be just like someone having cancer -
14 although we know more about the long-term course because
15 there's been more study - or someone with any other
16 condition in health, that if there's a severe, terrifying
17 condition that's likely to - could lead to the person
18 damaging their life or losing their life, then we would
19 treat it.
20
21 Q. Yes. You make a comment in your statement about an
22 analogy with other interventions in public health more
23 broadly, and you discuss the prevention of cancer and
24 similar diseases in connection with smoking.
25 A. M'hmm.
26
27 Q. And I think you say that at times one has to act on
28 the evidence as it is, rather than waiting until it
29 develops.
30 A. Yes. Taking us back then to the idea, say, of primary
31 prevention in terms of the so-called upstream determinants
32 of health, that if we see that there is, in terms of the
33 pattern of disorders, an increase of both physical and
34 mental health problems in adults with these experiences of
35 harm and neglect, well then, we might feel it's appropriate
36 to act that way.
37
38 To say, as the state, as Victoria has done with
39 Commissions on family violence and institutional care for
40 children, we have the understanding now that there is
41 unfortunately many - that it's in front of our eyes that
42 these experiences are quite common in the community, so
43 what we can do to prevent them happening will be important
44 also downstream for the mental health for the population.
45
46 And also, we can monitor what we're doing, not
47 necessarily by waiting 30 years so see who gets well or

1 ill - who is well or ill, but to say, well, the first thing
2 that we would find is that these particular regulations are
3 in place and the violence is abated and hence - and we
4 might anticipate, because of those links, that the further
5 results will be better.
6
7 Q. Yes. Can I just ask you one more question about this
8 topic. You have said in your statement that:
9
10 "Essentially the case for investment in
11 prevention requires a degree of
12 specificity. We need to examine the
13 specific cross-sectorial interventions that
14 are known to act on modifiable influences
15 on mental health."
16
17 Can I ask you to elaborate on that by explaining what
18 you mean by the cross-sectorial interventions and to the
19 modifiable influence on mental health?
20 A. Broadly, we could say that mental health is
21 everybody's business, so that, we understand that the way
22 children experience school, the relations with the teachers
23 and their peers, whether children are bullied or not, these
24 have a significant influence on their mental health.
25
26 We also have evidence that, from a range of different
27 places, that specific training in social skills, if you
28 like, for children is effective in improving their mental
29 health and improving their prospects of mental health.
30
31 Another example is from the field of community
32 development in a number of high income countries, including
33 in this country, there are community groups in a scheme
34 called Communities That Care that work together with
35 experts to assess the local situation in terms of youth
36 violence in communities and put in place measures to change
37 that, and this has produced significant results in terms of
38 reductions in youth crime and improvement in outcomes for
39 education and later vocation.
40
41 Q. Do you happen to know where in Australia these things
42 have been implemented?
43 A. Well, there have been some schemes in Victoria, in
44 Melbourne, as I understand.
45
46 Q. Just on the question of young people. You said that:
47

1 "Adequate access to services and early
2 intervention for those that need it [is
3 best practice]. Most of those needing help
4 are young people as the peak age of onset
5 of these conditions is between 15 and
6 25 years of age."
7
8 Can you just explain to the Commissioners what you
9 mean in that context about "the peak age of onset" and are
10 you referring to particular types of mental illness?
11 A. Well, it's across a fairly wide range of mental
12 disorders, mental illnesses, that this applies; that
13 between the ages of 15 and 25 - although sometimes for even
14 younger ages - but that period would be the time when most
15 people who are going to develop depression, who are going
16 to develop anxiety, a psychotic condition, that would be
17 the time when it first begins; may not be recognised then,
18 but that's usually the time that it begins.
19
20 And this distinguishes the mental disorders from the
21 other non-communicable disorders, in fact. Here we're
22 dealing with, we're thinking of cancer and heart disease,
23 we're thinking of people at the end of their working lives
24 or post working life; here we're talking about people who
25 are entering community life before they've had an education
26 or support - established their own families.
27
28 Q. You talk about the importance of linking primary
29 health and community based mental health services with
30 social housing and employment services. What, in your
31 view, is the importance of that linkage?
32 A. Yes. Well, this is important in general life, I
33 suppose --
34
35 Q. Yes, of course.
36 A. -- in supporting people in families and preventing -
37 promoting health, but in particular it's important if we
38 turn to the question of treatment and support and care for
39 people with the experience of mental ill-health and their
40 families. And again, working closely with these people
41 also, so that it's supporting the decisions of the people
42 with these conditions.
43
44 But we see that people's needs are not limited to the
45 health system, that they need somewhere to live, they quite
46 often might have combined health problems, like
47 drug/alcohol problems combined with mental health problems;

1 they might have a physical health problem as well,
2 particularly as people enter middle age, they tend to have
3 premature onset of those other non-communicable diseases.
4
5 So, in many systems, including to some extent our own,
6 we have some separation indeed in the sense of specialist
7 mental health services and their links and interchanges and
8 sharing of care, and some separations between the mental
9 health and the drug and alcohol services and the ability
10 for one service to manage all of those conditions.
11
12 Q. You've also spoken about the importance of
13 policymakers in different sectors having a combined and
14 comprehensive approach, and is that for similar reasons?
15 A. Yes, I think this is particularly so if we think about
16 persuading the Minister of Education to take an interest.
17 How can we persuade the Minister for Education during the
18 ride in a lift that mental health is important for his
19 portfolio or her portfolio?
20
21 And the same resources that are used to deliver
22 education now could be shaped at the same time to improve
23 rather than - or to improve mental health and to avoid any
24 inadvertent compromising of mental health.
25
26 Q. Thank you. You talk about some barriers to
27 implementing mental health promotion strategies, and one of
28 the things you have observed is confusion and vagueness
29 about what mental health itself is. Can you say a bit more
30 about that?
31 A. Yes. I think again, coming back to the idea that we
32 are not used to, as a community, to thinking about mental
33 health in itself, it's very much a part of health, and it's
34 different from, although linked to, mental ill-health. So,
35 thinking of mental health as an asset, being able to
36 describe it as something that benefits the person in the
37 community, that supports productive relationships, supports
38 work, and supports the person's own sense of peace and
39 wellbeing.
40
41 And, without that - I think we quite often conflate
42 mental health and mental ill-health when we're speaking
43 and, without understanding that - we sometimes use the
44 analogy of physical health, that an Olympic athlete has a
45 different state of physical health from many of us in the
46 community. We all still regard ourselves as healthy, but
47 we understand what to do to improve our health. We demand

1 from our governments that they don't let raw sewerage run
2 down the streets or that we want them to control alcohol
3 outlets, we want them to control the amount of fat and
4 label our foods. So, it's getting to the point where the
5 community demands this of our government and supporting
6 them in that.
7
8 Q. And having worked in public mental health for quite
9 some time, in your view where does that lack of
10 understanding of the importance of mental health lie in our
11 society?
12 A. Well, I think people have been very afraid of mental
13 ill-health. It is a very - it's a terrifying idea, people
14 have all sorts of misunderstandings about where it comes
15 from: is it a curse, is it a weakness? And the idea that
16 we could think about mental health as well is mixed up with
17 that and not fully separated.
18
19 And also, we're not used to thinking, as I mentioned
20 earlier, that mental health is part of overall health and
21 that a state of mental ill-health is going to compromise
22 the rest of health. What this confusion and vagueness
23 means, is that, we're not aware as a community of the
24 benefits to be gained from improving mental health, both
25 from promoting it and from preventing and treating illness
26 successfully; that mentally healthy people are going to be
27 more productive and the education system will be more
28 successful with its outcomes, and parenting will be - we'll
29 be able to support - parents may need or wish for some
30 support in what they're doing; early childhood development
31 can pick up early problems in learning or in relationships
32 and can again manage those early and help the families to
33 cope.
34
35 Q. So from a public health perspective would you say that
36 where we're at is still at a state of needing some
37 consciousness raising about mental health?
38 A. I think so, yes. Consciousness not necessarily in the
39 sense of campaigns, that can be helpful, but particularly
40 in government or in decision-making circles about what is
41 the evidence about the link between good mental health and
42 the other parts of community life, the ones I've mentioned,
43 and putting this alongside the need to raise awareness also
44 of what is mental ill-health and relieve the stigma and
45 discrimination that stand in the way of good service
46 provision and good support for those people.
47

1 Q. So, in that connection, is it your view that there's a
2 kind of institutional stigma in relation to mental health
3 and policy making?
4 A. Yes, I think that's probably a good way to put it.
5 People often minimise or believe it's a luxury or a fringe
6 interest, whereas things like this new UN or WHO Commission
7 on the non-communicable diseases has for the first time
8 included mental health; that's because it's critical to the
9 delivery of - successful delivery of services to other
10 forms of ill-health; it's intertwined.
11
12 Q. You've also spoken about what you call an unwarranted
13 pessimism about the efficacy of treatments for mental
14 health. What have you observed about that and where do you
15 think that pessimism lies? Who holds it?
16 A. Right. Well, it's the general community and often the
17 professional sense, I think we were all taught as medical
18 students, if you like, about what's called the clinician's
19 illusion and we're all warned about it, that we as
20 professionals see people who need to come and see us, that
21 is, people who are not well. People who get well don't
22 come back.
23
24 So, it's always the case, and we were taught to keep
25 this awareness with us, that we can't discern the pattern
26 of disease in the community from our daily work and it
27 requires another lens, another - studies of communities and
28 the patterns of ill-health and disability and health in
29 communities to work that out.
30
31 Q. You speak quite a bit in your statement about the need
32 for integration of various things, can I just ask you about
33 those. You say:
34
35 "We're yet to fully integrate the housing
36 system, mental health and drug and alcohol
37 services and the primary healthcare
38 system."
39
40 Now, there are a number of parts in that. If you can,
41 can I ask you what your vision is for integration in that
42 respect.
43 A. Could I say first that I'm basing quite a bit of what
44 I say on observations from --
45
46 Q. Yes.
47 A. -- the 1990s and the 2000s when I was director of the

1 Mental Health Service in the city and from studies we did
2 at that time on people with homelessness and mental
3 ill-health, as well as those in other parts of the mental
4 health service.
5
6 The importance of being able to deal with all of those
7 problems, with mental ill-health, with addictions, with
8 housing, lack of adequate housing, they all fuel each
9 other, and when people come into a mental health service it
10 doesn't do them much good to go back necessarily to a
11 boarding house with very little income.
12
13 They may not have anything that they regard as
14 meaningful to do, they may have - they may be socially
15 isolated, all of which are toxic to their mental health and
16 that can result in - when I began training in psychiatry we
17 had longer term hospital stays and people would just come
18 back. I remember seeing young people who would come back
19 two or three times within a very short space of time
20 because the conditions in which they lived were toxic to
21 their mental health.
22
23 I think we've become much more sophisticated now about
24 managing that but not completely so, and that's partly
25 because people on the ground - the drug and alcohol
26 workers, the mental health workers, the housing workers may
27 not be familiar with and may be frightened of dealing with
28 the other two problems that they're not used to.
29
30 Q. You also mention your view that there is a need for
31 close alignment between the mental health system and the
32 child protection system. Can you say a little about that?
33 A. Yes. Well, I think we can look first at expenditure,
34 relative expenditures; that if we look at the child
35 protection system, the bulk of the expenditure, as I
36 understand it across our country, is on the out-of-home
37 care system. Advocates would argue that we want to be
38 thinking about how to keep families together, how to
39 prevent the maltreatment and violence and the other causes
40 of removal of children from their families.
41
42 So, the mental health - the links between mental
43 health and the child protection system might be in both
44 stages: that, how can the mental health system or mental
45 health expertise, if you like, be integrated well into
46 family support, parental support, early childhood
47 development work.

1
2 And then, when children are in foster care, or kinship
3 care or in the minority residential care - again, we've
4 heard about some of that today - when they're in that
5 system, how do we support the carers of those young people
6 to understand their needs as well as provide any direct
7 support to the young people?
8
9 There's a great deal that can be done to support the
10 system as well as support individuals. I think it wouldn't
11 be unique for there to be difficulties in working across
12 systems and people understanding each other and how best to
13 work together.
14
15 Q. Just in that connection you say that:
16
17 "Maternal and child health services would
18 ideally work closely with mental health
19 experts for training and support of
20 midwives and nurses and other providers in
21 the detection and management of depression
22 and other perinatal mental health
23 problems."
24
25 A. Yes, I think we're very - probably world leaders in
26 this state in doing that.
27
28 Q. Yes.
29 A. And that's a good example that we could extend to
30 other systems.
31
32 Q. Yes. Can I ask you about a slightly different topic
33 although still on your views about how the system might
34 change. You said that:
35
36 "Suicide prevention and mental health
37 promotion have tended to be different
38 discourses up to now and a holistic view
39 would assist."
40
41 What do you mean when you say "different discourses"?
42 A. Well, we do some world-leading work again in suicide
43 prevention, and preventing suicide is a very broad canvas,
44 or ideally so. So that, there are specific things that we
45 can do in schools in terms of training, so-called training
46 of the gatekeepers to understand when there is a need to
47 intervene with some distressed person. We can prevent the

1 means of suicide, guarding bridges and all the things that
2 we do that way.
3
4 But we need to - and many people do but it's important
5 to include the broader canvas of promoting health,
6 promoting mental health. That, if we think of violence and
7 we think of alcohol and drug use, that the prevention of
8 these circumstances also is relevant to suicide prevention.
9
10 Q. Yes. You also say that:
11
12 "There are obvious coordination
13 difficulties in integrating services which
14 are administered by different institutions
15 and government departments. People with
16 poor mental health and related disabilities
17 need support from a trusted integrated
18 environment which can withstand the ups and
19 downs."
20
21 What, in your view, are the features of a trusted,
22 integrated environment that can withstand the ups and
23 downs?
24 A. Well, I think it's, we're looking for something that
25 may exist in some places, but the idea that a person or a
26 family can go to one place and tell their story and have -
27 be treated with respect and dignity. So, it's a question
28 of human rights, of treating people with mental ill-health
29 the way we would treat people with any other form of health
30 for a start, ill-health, and that sense of continuity, that
31 it's not a sense of having to transfer and move around to
32 find the different services, which is a very difficult
33 experience for people who are already experiencing mental
34 health problems.
35
36 Q. Professor Herrman, is there anything I haven't asked
37 you about in relation to your views for reforming the
38 system that you'd like to speak about?
39 A. No, I think we've covered a lot. I think the key
40 points perhaps would be the question of valuing mental
41 health, understanding the benefits for the community of
42 improved mental health, and of understanding that people
43 throughout their life course have mental health problems,
44 but for our community and every community it's the young
45 people that we are beginning much more to understand now,
46 this is when the problems begin and when we can intervene,
47 and that, if we think of the upstream determinants of

1 mental health and mental ill-health, there's a great deal
2 we can do by working with education, housing, parenting,
3 social welfare and workplaces.
4
5 MS NICHOLS: Thank you very much. Chair, do the
6 Commissioners have any questions?
7
8 CHAIR: No, I don't think so. Thank you very much for
9 that very comprehensive overview.
10
11 MS NICHOLS: May Professor Herrman be excused?
12
13 CHAIR: Yes.
14
15 **<THE WITNESS WITHDREW**
16
17 MS NICHOLS: That concludes the evidence for today,
18 Commissioners.
19
20 **AT 4.00PM THE COMMISSION WAS ADJOURNED TO**
21 **FRIDAY, 5 JULY 2019 AT 10.00AM**
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