

ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

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

On Friday, 26 July 2019 at 10.00am

(Day 19)

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

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

1 MS NICHOLS: Good morning, Commissioners. The first
2 witness today is David Martine, I call him now.

3

4 <DAVID JOHN MARTINE, affirmed and examined: [10.03am]

5

6 MS NICHOLS: Q. Mr Martine, are you the Secretary of the
7 Department of Treasury and Finance in Victoria?

8 A. Yes, that is correct.

9

10 Q. Have you had that role since 2014?

11 A. Yes.

12

13 Q. Prior to that, did you have a number of senior roles
14 in the Commonwealth public sector, including Deputy
15 Secretary of the Commonwealth Department of Finance and
16 Deregulation?

17 A. That is correct.

18

19 Q. And General Manager of Budget and Policy in the
20 Commonwealth Treasury?

21 A. Yes.

22

23 Q. Have you prepared a statement on the subject of
24 funding, including funding for mental health in the state
25 of Victoria?

26 A. Yes, I have.

27

28 Q. I tender the statement. [WIT.0003.0005.0001]
29 Mr Martine, can I ask you about the devolved governance
30 model for budgeting and reporting that we have in Victoria.
31 We have a devolved governance system in which departments
32 manage global budgets that are designed around the delivery
33 of agreed outputs aligned to Department objectives. Can
34 you tell the Commissioners briefly, within that system
35 governed by the various pieces of legislation and so on,
36 what are the mechanisms for ensuring accountability in
37 relation to the Victorian people receiving good value for
38 money invested and appropriate investment?

39 A. Okay. We have what we call a resource management
40 framework which, as you've described, is essentially a
41 devolved system of output budgeting. But in a devolved
42 system there are certain mechanisms to ensure
43 transparency --

44

45 Q. I might just ask you to speak closer to the microphone
46 if you would, thank you.

47 A. So we have a system that is a devolved system, but

1 does have elements to ensure accountability and
2 transparency. The way the resource management framework
3 essentially works is, it's centred around providing funding
4 at the output level, and those outputs are specified by
5 portfolio Ministers and then approved by the Assistant
6 Treasurer based on some advice that my Department then
7 provides, and they sit within an overall framework that
8 essentially has Department setting objectives, objective
9 indicators, outputs and then each output has a series of
10 performance measures.

11
12 And so, there's a process of both allocating funding
13 in that framework determined by Government, but along with
14 that there's a process of reports and scrutiny, both public
15 and within Government, in terms of the delivery of outputs.
16

17 Q. Can I ask you a fairly high level question about
18 accountability. What are the fundamental objectives of the
19 accountability regime as you describe it, from a policy
20 perspective?

21 A. I guess, the accountability framework, in a sense,
22 probably serves a couple of purposes. There's certainly an
23 important purpose within Government in terms of providing
24 the necessary information for the key decision-makers
25 within Government to ensure that outputs are being
26 delivered effectively and efficiently, and there's also the
27 important public role in that accountability as well which
28 involve certain reports to Parliament which might involve
29 the actual budget papers each year, along with departmental
30 annual reports is the other main mechanism that departments
31 report on their output performance.
32

33 Q. Who is the decision-maker in relation to the amount of
34 funding that gets given for the purposes of mental health
35 each year?

36 A. Essentially, the key decision-maker, or the mechanism
37 for making those decisions, is essentially the Expenditure
38 Review Committee of the Cabinet. Now, those mechanisms
39 vary according to governments, but the current Government
40 has an Expenditure Review Committee of Cabinet and that's
41 essentially the key decision-maker on all funding
42 decisions, including on mental health.
43

44 Q. We'll get to outputs in a minute, but they're supposed
45 to be aligned to departmental objectives, are they not?

46 A. That's correct.
47

1 Q. Who determines departmental objectives?

2 A. So, departmental objectives are put together by
3 departments, they're approved by the relevant portfolio
4 Minister, and they then have to be agreed by the Assistant
5 Treasurer, and my Department in that process then provides
6 advice to the Assistant Treasurer.

7

8 Q. What's the process for assessing the appropriateness
9 of departmental objectives beyond the level of the
10 Department?

11 A. So, the process: they would come forward from the
12 portfolio Minister to my Department, and I have an area
13 within my Department that is essentially mirroring the rest
14 of Government, it sort of shadows, so I have a health team
15 for example, and they would go through and assess the
16 objectives, objective indicators and performance measures,
17 and then they'd be providing advice to the Assistant
18 Treasurer for his approval.

19

20 Q. So, within the context of the current framework a
21 Department has a global budget: is there a mechanism for
22 overseeing or scrutinising the Department's decisions to
23 allocate funds within that global budget?

24 A. There is, and there's probably a couple of important
25 points I would like to make. So, we do have a devolved
26 system, however within the framework, as necessary, there
27 can be certain restrictions or requirements imposed by
28 Government.

29

30 So, in terms of the scrutiny of decisions the
31 Department might make, you can have situations where a
32 Government might decide that a particular service, or a
33 particular initiative, needs to be delivered a certain way.
34 So, from time to time a Government will get into quite a
35 bit of detail about delivery: not in all occasions but
36 there are certain examples of that.

37

38 Along with those sort of situations there is a
39 requirement of Departments reporting to my Department in
40 terms of changes in the mix of funding within outputs, and
41 then we ensure that there's scrutiny and there's some
42 formal reports twice a year that go through to the
43 Assistant Treasurer and through to Government as well.

44

45 Q. Can I ask you to perhaps apply that in the case of
46 some specific examples. This Commission's heard fairly
47 extensive evidence that the costs of Area Mental Health

1 Services are significantly above the amount of funding that
2 they receive. There's a lot of detail behind that, but if
3 you take that as a premise, what would be the mechanisms
4 within Government to look at that as a problem and work out
5 how to solve it? Is it just a matter of budgets coming up
6 to Treasury, or business cases coming up to Treasury
7 each year, or is there a higher level at which that sort of
8 question is examined from Government's perspective?

9 A. Generally, most funding decisions are considered in
10 the budget process, and the reason why that occurs is, it
11 enables the Government of the day to assess relative
12 priority, so that's generally the time that funding
13 decisions are made - not in all situations - and in that
14 context a portfolio Minister would be bringing forward a
15 proposal. In a situation that you described, where there
16 are demand pressures or unfunded pressures, that would be a
17 key element of their business case that would be brought
18 forward for consideration by the Expenditure Review
19 Committee, and my Department, along with the Department of
20 Premier and Cabinet, would be assessing those proposals and
21 providing advice to the Committee.

22
23 Q. Is the baseline on which that is done the business
24 case that's put up by the Department?

25 A. The business case is certainly an important part of
26 consideration of the proposal, but it's not the only bit of
27 information that's taken into account. So, we would, in
28 assessing a particular proposal, be drawing on other
29 reviews or reports that might exist, or just experience
30 that policy advisors may have built up over time, so it's a
31 matter of bringing all the information together to provide
32 the right sort of advice to the Committee.

33
34 Q. In this model, the Department sets prices, is that
35 right, that services are paid?

36 A. Generally, yes, but it depends a bit on the nature of
37 the output and the nature of the delivery and, as I
38 mentioned earlier, there are situations where Government
39 naturally wants to have a proper detailed discussion about
40 delivery, so they might actually have quite explicit
41 decisions coming out of the Expenditure Review Committee
42 about price, delivery, they might even relate to situations
43 such as location of delivery services. Sometimes you may
44 have an example where a decision is made to provide funding
45 but the relevant Minister might be asked to come back in
46 six months' time with a detailed implementation plan which
47 might include pricing and other elements for the Committee

1 to actually endorse.

2

3 Q. There is now a Chief Financial Officer in each
4 Department that reports directly to you, is that right?

5 A. That's correct. All departments have always had a
6 Chief Financial Officer, but one of the election
7 commitments that the Government had back in November was to
8 have all Chief Financial Officers now report to myself.

9

10 Q. In the Department of Health and Human Services,
11 specifically in relation to mental health, what do you
12 expect of the role of that person?

13 A. So, the Department of Health and Human Services has a
14 single Chief Financial Officer which covers the whole
15 breadth of the Department.

16

17 The rationale behind the election commitment from the
18 Government is to improve essentially the transparency part
19 of the model I described earlier. So, we've got devolution
20 balanced against accountability and transparency, and the
21 background to this particular election commitment is to
22 enhance the transparency component of the model with
23 information coming back to the centre so that there's more
24 information and advice going to the Expenditure Review
25 Committee.

26

27 Q. So that's transparency within Government going
28 upwards?

29 A. That's correct.

30

31 Q. To use a specific example, the Commission's heard
32 quite some evidence about disparity in resourcing between
33 catchments, particularly in relation to growth corridors,
34 who seem under-resourced compared with their population
35 growth and by reference to the burden of mental ill-health.
36 A question like that which is systematic, who in that
37 matrix of people would look at that outside in response to
38 a particular business case?

39 A. So, it could be a combination of either the Department
40 through their Minister raises that as a particular issue
41 that Government needs to address, or it could come from
42 either my Department or the Department of Premier and
43 Cabinet in assessing a proposal, giving advice to the
44 Committee that might give different options or ways forward
45 to actually spend a particular amount of money.

46

47 So, certainly, a lot of the advice we focus on is all

1 about efficiency and effectiveness, and the point that has
2 been raised is often about that effectiveness question.

3
4 Q. Can you say what you mean by that in that context, the
5 effectiveness question?

6 A. It's all about, what's the most effective way to deal
7 with the particular problem that has been brought forward
8 to the Committee to consider.

9
10 Q. What about the question of the transparency of how
11 Area Mental Health Services are funded? This Commission's
12 heard evidence that, from their perspective, they don't get
13 transparency about funding decisions and why certain
14 services are funded, apparently, at a different level than
15 others. Is that a question simply for the Department or
16 does it involve your Department as well?

17 A. Certainly we as a Department and within Government
18 would get access to some transparency. In terms of the
19 relationship that the Department of Health and Human
20 Services might have with some of the service providers is
21 probably a bit difficult for me to comment on.

22
23 Q. Yes, that's a matter for the Department of Health and
24 Human Services, would you say?

25 A. Generally, yes, but as I mentioned earlier, there are
26 situations where, depending on the nature of the service
27 delivery, governments may actually get quite involved in
28 the detail of how it's actually going to be delivered, and
29 in that context there could be quite a bit of detail and
30 transparency about where funding would be provided and to
31 which providers.

32
33 Q. Could you provide an example of the kind of situation
34 you're alluding to now?

35 A. Perhaps a good example, and this is going back a
36 couple of budgets, is family violence. So, the Government
37 had made family violence a major funding priority three
38 budgets ago, and I think from memory in that budget there
39 was an allocation of I think about \$1.9 billion over
40 four years, so it was a very big package. In the context
41 of the development of that package, there were quite
42 detailed discussions about both the scale of the
43 investment, but also delivery, and there was also
44 discussions about mechanisms to ensure that those
45 initiatives are then delivered over a period of time.

46
47 So, that's I guess the other important point about the

1 funding model: yes, it is devolved, but that doesn't stop
2 governments as necessary imposing or putting in place extra
3 transparency and accountability requirements.
4

5 Q. So, is the essential point that, provided an issue is
6 a sufficient priority at the Government level, there is a
7 considerable amount of latitude for ensuring that the
8 correct objectives are met and met properly and
9 efficiently?

10 A. Certainly the resource management framework,
11 I believe, is flexible enough to accommodate a range of
12 requirements and, if Government makes a particular area a
13 priority, they can, under the existing framework, put in
14 place a whole series of delivery requirements and
15 accountability requirements, and none of those are
16 inconsistent with the framework; they do work side-by-side
17 and there's been numerous examples of those.
18

19 Q. Thank you. This Commission's heard considerable
20 evidence that the Department has very limited capacity, or
21 still has rather, a limited capacity to do detailed
22 population-based planning and has significant
23 data-gathering and assessing inadequacies, and that's in
24 the context of there being a very significant gap between
25 supply and demand. Are those sorts of systematic issues
26 capable of being adequately addressed through the existing
27 devolved governance funding model?

28 A. I think they are. Forecasting demand is quite
29 complex, and it all comes down to ensuring you've got the
30 right sort of data, but I don't see any of that
31 inconsistent with the current funding model at all.
32

33 Q. What are the mechanisms within the current model for
34 addressing underlying and chronic problems of a gap between
35 supply and demand that are putting extraordinary pressures
36 on the mental health system?

37 A. So, most demand pressures from a funding point of view
38 are considered by Government through the budget process.
39 So, where a particular area of Government spending - and
40 generally they fall into two portfolios: Health and
41 Education, they're the two areas that are generally driven
42 by demand pressures.
43

44 The proposals that come forward for consideration by
45 the Expenditure Review Committee do deal with the demand
46 pressures and the Committee has those discussions and then,
47 on the basis of the information that is provided in terms

1 of demand pressures and forecasts, makes then a decision
2 for the additional funding that's then allocated. So, it's
3 essentially done on an annual basis generally through the
4 budget process.

5
6 Q. Can I return to the question of output funding: can
7 you give an example of an output in mental health?

8 A. Essentially, there's the large mental health output
9 which I think from memory is about \$1.6 billion. In total
10 there's \$1.7 billion spent.

11
12 Q. So, from Treasury's perspective, an output is an
13 outlay of money, but in relation to what the Department
14 delivers in return for that funding, what are the measures
15 of what it delivers? What's an example of an output in
16 that context?

17 A. Well, the funding is provided at the output level, and
18 each output would then have a series of performance
19 measures against that output, which generally fall into the
20 categories of quantity, quality and timeliness.

21
22 Q. Who determines the output measures?

23 A. So, they're brought forward by the relevant portfolio
24 Minister for approval by the Assistant Treasurer, and my
25 Department in that process would assess the performance
26 measures in discussions with the relevant departments, and
27 provide them feedback and then give advice to the Assistant
28 Treasurer, but they do need to be agreed jointly by the
29 portfolio Minister and the Assistant Treasurer.

30
31 Q. Within that process, what measures exist to ensure
32 that the output measures are capable of identifying and
33 meeting questions of demand and gaps between supply and
34 demand in the mental health system?

35 A. So, often in terms of demand pressures, you would
36 probably see those issues manifest themselves probably in
37 two ways in the performance measures. Firstly, in some of
38 the quantity performance measures depending on how they're
39 structured, and then secondly demand pressures could very
40 well flow through to what you see in actuals against
41 targets for, for example, timeliness measures.

42
43 So, you could have a situation where demand pressures
44 put enough stress on a system that timeliness doesn't meet
45 the target, and often then the explanation as to why the
46 target hasn't been met is because of demand pressures.

47

1 Q. Can I take you to a particular example of that. In
2 your statement at paragraph 72 you say:

3
4 "Performance measures for clinical care
5 output include quantity measures such as
6 the annual number of clinical inpatient
7 separations, and occupied residential
8 subacute bed days, as well as quality and
9 timeliness measures such as the number of
10 designated mental health services achieving
11 or maintaining accreditation ...", and so
12 on.

13
14 Do you have that paragraph there, Mr Martine
15 A. I do.

16
17 Q. You go on to say that:

18
19 "Performance against targets in the
20 clinical care output were met in 2017/18,
21 with the exception of the proportion of
22 emergency patients admitted to a mental
23 health bed within eight hours (which was
24 57.5 per cent relative to a target of
25 80 per cent)."

26
27 To take that as an example, we've heard evidence in
28 this Commission that, in relation to mental health
29 patients, there are regular exceedances of even the 24-hour
30 measure, and the substance of Ms Peake's evidence yesterday
31 was that she accepted that there is very little that
32 Emergency Departments can do for mental health patients
33 waiting over 24 hours.

34
35 In the context of that sort of measure, what happens
36 in the performance management framework when that measure's
37 not met, to use that as an example?

38 A. Well, that's probably a good example to draw on. When
39 a Minister is bringing forward a proposal, particularly in
40 the budget process, for additional funding, one of the key
41 bits of evidence that would support that business case is
42 to actually draw on what's actually happening, and that's
43 where the performance measures can be quite useful, in that
44 they can be presented in a way through the funding
45 decision-making process, that a particular program is not
46 delivering on the Government's expectations, it's not
47 delivering on its objectives, that can be seen in the

1 performance measures against the targets, and that forms an
2 important element of the case put forward for additional
3 funding.
4

5 Q. Are you able to say what has happened in the case of
6 this particular non-conformance with the performance
7 measure?

8 A. I'd probably have to --
9

10 Q. I appreciate that is a question without notice.

11 A. Yeah, I'd probably have to take that on notice to
12 provide any further details. It is acknowledged in Budget
13 Paper No.3, p.208, there's a brief explanation of why the
14 target wasn't achieved. The question of what was then done
15 about trying to address that is something I'd have to take
16 on notice, because it's something that I'd need to check.
17

18 Q. Alright, we might take that off-line, noting that as a
19 question on notice. But would you expect, as a matter of
20 process, where there is a non-conformance like that one
21 which is in the context of there being not a great deal of
22 performance output measures, that that would be followed up
23 in terms of why it hasn't been met and what steps are going
24 to be taken for it to be met in the next cycle?

25 A. I do, and a part of the performance management
26 framework is we provide an assessment to the Assistant
27 Treasurer twice a year and he takes that forward to
28 Government for consideration.
29

30 So, where performance measures aren't being met, they
31 get drawn out in that report, and then that gives
32 Government the opportunity to have a discussion about the
33 reasons behind why they haven't been met and whether
34 there's some remedial action that at that point the
35 Government may want to take.
36

37 Q. I see. Would you accept that the capacity of the
38 Government at the level of Treasury and the Expenditure
39 Review Committee to determine whether the mental health
40 system is actually meeting demand and meeting the mental
41 health needs of Victorians very much depends upon the
42 adequacy of the performance output measures?

43 A. They're certainly very important to be able to assess
44 delivery, there's no question about that.
45

46 Q. Thank you. The evidence in this Commission has been
47 that there's been a significant level of underfunding of

1 the mental health system over a very long period of time.
2 My question is: what has led to that, in your assessment?
3 A. This is a very difficult question to answer in terms
4 of why there's been underinvestment. Certainly in the
5 Government's submission to this Commission, the Government
6 notes that funding hasn't kept pace with demand, and that
7 is despite quite a significant increase in the mental
8 health output since 2010. So, funding's actually risen by
9 71 per cent, from 1 billion to 1.7 in 2019/20, but despite
10 that increase it hasn't kept pace with demand.

11
12 I'll perhaps make a couple of observations on that.
13 Certainly at the macro level, probably since 2013, we have
14 in the Treasury underestimated population growth here in
15 Victoria. It's always been on the upside; to the point
16 where over the last few years the population in Victoria
17 has been growing quite significantly above the national
18 average: we're sort of at about 2.2 per cent versus the
19 rest of the nation at about 1.6. That places a lot of
20 pressure on both Government services and its
21 infrastructure.

22
23 So we have gone through a period, particularly since
24 about 2013, where quite a lot of investment by governments
25 has been required in the areas of Education, Health and
26 infrastructure in particular to deal with that population
27 growth, so that's put some pressures on the system.

28
29 In terms of then trying to forecast demand pressures
30 for mental health services is, I think, incredibly complex,
31 and that comes back to the point of trying to get much
32 better information and data to make those forecasts.
33 There's no question that the complexity of society over the
34 last decade has made it a bit more difficult to try and get
35 a good understanding of the demand. There's identified
36 demand, but then there's also unidentified demand for
37 services, so it's hard to get a good sense of what that
38 really is.

39
40 I think that's one reason why I suspect it has been
41 difficult for governments to keep pace with the demand on
42 services. The second point I'd probably make in terms of
43 the "why" question: based on my experience, I've always
44 found it gets quite complex in areas of policy delivery
45 where you have different levels of Government all in the
46 same area, and mental health's an example where you do have
47 the Commonwealth particularly responsible for primary care

1 and the state responsible at the acute care end, and the
2 Government submission does talk about that sort of missing
3 middle bit.
4

5 Often you will see, where you have different levels of
6 Government providing services, it does add an extra layer
7 of complexity. But at the end of the day, these are all
8 decisions that governments need to make in a, what I'd
9 describe as a sort of constrained resource environment, and
10 that's where it gets difficult for governments because
11 they're all competing demands in terms of, particularly
12 through the budget process.
13

14 To perhaps give you a sense of scale, if you look at
15 the last few budgets, the Government has spent probably
16 close to about \$10 billion over four years on new
17 initiatives. To get to that point you're probably sifting
18 through maybe three times that amount in terms of proposals
19 that then need to be condensed down into something around
20 the 10 mark. So, it's not an easy task then to make those
21 relative priorities, so I think it's a combination of all
22 of those factors to try and address that question of, why
23 is it that we have underinvested over a period of time in
24 mental health services.
25

26 Q. Can I tease out some of those things. On the question
27 of demand being difficult to grapple with and to the
28 difficulty of understanding population pressures: we heard
29 evidence yesterday that the likelihood that there would be
30 even more significant population pressures in 2019 than
31 there were 10 years earlier was well understood, at least
32 at the Department level, and during that time there has
33 remained an inability to gather and analyse adequate
34 information to understand the demand pressures and the
35 corresponding needs.
36

37 Do you accept that that's been a longstanding problem
38 and, if so, what do you think can be done about it?

39 A. Well, there's probably two parts I think to your
40 question: one is, population in general for Victoria which,
41 as I accept, we have underestimated that growth. And, it
42 is hard to forecast population. We are forecasting a bit
43 of a drop off in population based on the evidence we have,
44 but whether that will eventuate is hard to tell.
45

46 But I think the more relevant part of your question
47 is, within the Victorian population forecasting the demand

1 for mental health services, and there's no question that we
2 need to get much better at doing that and I think the key
3 is to get much better information and data. But it is a
4 complex area because you are dealing with both an expressed
5 demand or an identified demand and an unidentified demand.
6 There's no question that, as a result of that, the system
7 is not working and it is underfunded.

8
9 Q. In relation to your observations about the missing
10 middle, which in large part although not entirely
11 corresponds to the area that the Commonwealth funds, the
12 evidence given yesterday and also in the Victorian
13 Government's submission was that, right across the spectrum
14 of mental health and mental illness, there are very
15 substantial gaps: so, at the front-end as well as at the
16 more acute end and the middle.

17
18 Can I ask you to return to my question with that
19 background about why it is that there's been a chronic
20 underinvestment in mental health: is it a question of
21 Government prioritisation, do you think?

22 A. That's always part of it. As I answered in one of
23 your questions, at the end of the day all funding flows
24 from Government decisions in a constrained fiscal
25 environment. There's all a constraint on what can be
26 spent, and so, governments need to then assess relative
27 priorities.

28
29 Most proposals that come forward have merit and it's a
30 difficult task for both advisors and governments to then
31 assess a relative priority across the full spectrum of all
32 portfolios to work out how to allocate a constrained set of
33 resources.

34
35 Q. In circumstances where, because of the state of the
36 mental health system, investment may be required that is of
37 an order of magnitude greater than that already existing in
38 order to fix the system, how will the current model of
39 funding manage that, do you think?

40 A. Well, that issue will obviously need to be then
41 considered by the Government through the normal budget
42 process, but generally there's only three ways that
43 governments can pay for things: you either cut spending in
44 another area to fund more spending in a particular area;
45 you either raise taxes to fund something, or you increase
46 borrowing, so it's essentially one of those three, but
47 those matters would need to be considered by the Government

1 through a budget process.

2

3 Q. In the context of the most recent budget, for 2019,
4 the allocation for mental health was 42 per cent above that
5 allowed in 2014/15. What were the factors in your
6 assessment, without revealing privileged information, that
7 allowed for a very substantial increase in funding to
8 mental health?

9 A. Well, probably the last three budgets there's been
10 reasonably significant additional allocations to mental
11 health, particularly last year's budget: it was
12 \$587 million over four. This year's budget certainly less,
13 but in a way not particularly surprising given the Mental
14 Health Royal Commission is underway and it's not an unusual
15 thing for governments to wait for outcomes before
16 allocating some additional funding.

17

18 I think the real reason really comes down to a point I
19 made earlier, which is, a priority set by Government, and
20 that's really often the key in all of this, and we saw that
21 with family violence three budgets ago. When something
22 becomes a priority for the Government of the day, then that
23 really drives the decision-making process.

24

25 So, on mental health, without disclosing detailed
26 discussion, it clearly became a priority for the current
27 Government and a recognition that the current system is not
28 working and needs some additional funding, so that sort of
29 led to both some additional funding and other things such
30 as the establishment of this Royal Commission.

31

32 Q. Thank you. Can I ask you a little bit more about
33 outcomes-based funding and the moves away from it
34 potentially. You have discussed in your statement the
35 challenges, I suppose, that outcomes-based funding pose.
36 What are the issues related to the measurements of outcomes
37 that Treasury needs to grapple with in mental health?

38 A. I'll assume that the question largely relates, not so
39 much to outputs but outcomes?

40

41 Q. Outcomes, yes.

42 A. So, in our current framework, essentially the
43 objectives and objective indicators are essentially the
44 outcomes that Government is looking to achieve, and so the
45 outputs sit below that. A lot of the objective indicators
46 generally tend to be a little bit more medium term
47 measurement. So, the output performance measures are

1 essentially annual measurement, and it's not unusual to
2 then see the objective indicators to be providing a bit
3 more of a medium to longer term set of measures where a
4 Government ultimately wants to end up in a particular area.

5
6 Q. So, is there a need to link the outputs year-on-year
7 with the longer term outcome measures?

8 A. Yes. So, the whole purpose of the framework is, it
9 builds up from the bottom, so the outputs need to feed
10 through to the objectives. There's no point having an
11 output that's not delivering on a Government objective.

12
13 Q. In terms of the potential for changing funding models
14 in relation to mental health, the question of
15 activity-based funding has been on the agenda for a long
16 period of time, but mental health has been largely stuck
17 with block funding. In your assessment, what's been the
18 reason for the long period of time that it's taken to
19 reassess?

20 A. I think it comes down to the complexity of
21 activity-based funding in an area such as mental health.
22 And I preface my answer with the fact that I'm not an
23 expert clinician, but in a whole range of areas in health,
24 particularly in the sort of physical injury, the definition
25 of an activity I think is a little bit more certain.
26 Because for activity-based funding to work, you've got to
27 identify the activity and then price it.

28
29 I think there's a little bit more consensus around
30 diagnosis and treatment in a range of physical injuries
31 more so than in the area of mental health, and that I think
32 adds some complexity about, what is the activity that is
33 identified to then be appropriately priced?

34
35 So, it is a difficult change to make, it's not an easy
36 one and, once again, a lot of that comes down to getting
37 the right sort of data and information to help support
38 that.

39
40 Q. We'll turn to alternative funding models shortly, but
41 it is now accepted, isn't it, that there are a significant
42 number of difficulties with block funding and that there's
43 a desire to move away from it?

44 A. Generally, that is correct, and we as the Department
45 do support that. There are situations where block funding
46 is relevant. So, for example, in the current system for
47 very small hospitals in Regional Victoria we use block

1 funding, because that provides a bit more stability and
2 certainty. So, as a general proposition I agree, but there
3 are some situations where block funding would actually be
4 more appropriate.

5
6 Q. You've said in your statement that DTF plays an
7 important role in supporting Government to explore
8 innovative ways in funding, including in the context of
9 outcomes-based funding and you have mentioned Partnerships
10 Addressing Disadvantage: can you say what those are?

11 A. So, there's been a couple of initiatives that have
12 been led by my Department in terms of looking at different
13 ways of delivering Government services. The Partnerships
14 Addressing Disadvantage which we're currently developing is
15 really an extension of two social impact bonds that we were
16 responsible for establishing, and they've been announced
17 and they're now just underway.

18
19 One relates to chronic homelessness, and the other one
20 relates to children leaving out-of-home care. The whole
21 purpose of these models is to take some Government funding
22 and connect it with some private sector funding and have
23 delivery through - it might be a not-for-profit or a
24 service provider, where there's some clear outcomes
25 established and some clear targets for them to deliver on
26 and, if they're actually delivered, then in a sense the
27 private sector investors who have provided that funding for
28 the service in a sense get their capital and a return back.

29
30 So, it's an interesting model. A number of
31 jurisdictions have explored those concepts of social impact
32 bonds, and is a very similar --

33
34 Q. The same thing.

35 A. A very similar sort of thing. The other point I'd
36 make about more innovative ways of delivering Government
37 services, and it's something that we as a Department would
38 be providing relevant briefing on, is designing services
39 more around the delivery for an individual rather than
40 generic programs.

41
42 There's quite a bit of evidence out there that program
43 effectiveness can be quite enhanced through tailoring
44 services more around the needs of an individual, rather
45 than just a set of generic requirements. So, that's
46 something that we would examine potentially through a
47 budget process to be providing advice on, there might be a

1 better way of delivering services.

2

3 Q. Can I get you to say a little bit more about that.
4 So, in that context, how would the funding work? Does the
5 funding follow the individual?

6 A. Generally it can, and NDIS is perhaps a good example
7 where the model is around building up a package for an
8 individual. So, there'd be a bucket of money provided for
9 a suite of services, but then there's more discretion
10 around how that funding is actually spent, and it's more
11 targeted for what the individual actually needs, and that's
12 where you get the enhanced effectiveness from that
13 particular model.

14

15 Q. To what extent has that potential model been
16 considered at Treasury level?

17 A. So, we would consider that as part of our assessment
18 of proposals that come forward, and proposals do from time
19 to time come forward; they're a little bit more centred
20 around individuals. And, perhaps I should just add, it's
21 not just about individuals; sometimes you may focus on
22 locations, for example. So, you might, rather than have
23 generic programs, you might target it a bit more to a
24 particular location, or it might sit in between which might
25 be a particular cohort. There are different sort of
26 models, but the general point there is, having programs a
27 little bit more targeted can improve effectiveness of
28 what's actually provided.

29

30 Q. Has this been considered for a whole-of-system roll
31 out, or is it just an idea that is being contemplated or
32 piloted in relation to a smaller aspect of the mental
33 health system?

34 A. Well, I think the Government submission talks a bit
35 about moving more in that direction on mental health, so I
36 think there's a movement: it's not, you know, big scale,
37 but there's movement at the moment down that path.

38

39 Q. The extent to which Partnerships Addressing
40 Disadvantage, what is the extent to which that could be
41 rolled out in different areas across the mental health
42 system? Do you think it's limited, for example, to the
43 provision of psychosocial supports or something broader
44 than that?

45 A. You'd have to look at the circumstances, but there's
46 no reason why a number of those particular delivery models
47 couldn't at least be examined as part of whether that's a

1 better way of delivering services.

2

3 Q. So, is it fair to say that Treasury has an open mind
4 about the future for funding models in mental health in
5 Victoria?

6 A. Yes.

7

8 Q. Can I ask you about the NDIS and your evidence about
9 the eligibility criteria and the work that Treasury is
10 doing in relation to the restrictive criteria that apply
11 currently under the scheme?

12 A. So, most of our work and responsibility for the NDIS
13 essentially relates to the interaction with the
14 Commonwealth particularly around what it means for funding.

15

16 Q. But you make some observations in relation to the
17 difficulties for people who are presently not eligible
18 under the scheme. I'll direct you to paragraph 130 of your
19 statement, where you say:

20

21 "Ensuring that the NDIS responds to the
22 needs of people with mental illness and
23 psychosocial disability is a further area
24 of discussion with the Commonwealth. This
25 could include reviewing how eligibility
26 criteria recognise the unique needs of
27 people with a mental illness given the
28 episodic nature of mental illness ...", and
29 so on.

30

31 Is that an area you're identifying as having potential
32 for discussion between Victoria and the Commonwealth?

33 A. Correct, and that's really relevant to one of my
34 earlier points about where you've got two levels of
35 Government, and really the point there is, for those people
36 who fall just below the eligibility criteria, there's an
37 important discussion that both jurisdictions need to have
38 about how they are actually treated so that they just don't
39 slip through the cracks.

40

41 Q. Can I ask you about the support, the continuation of
42 support that's being provided for people in the transition
43 phase to the NDIS?

44 A. Yes. So, there is some support that's provided for
45 transition.

46

47 Q. How does that work on a practical level?

1 A. That's probably more of a question for DHHS in terms
2 of how that is actually working in practice.

3

4 Q. Alright.

5 A. I probably don't have that knowledge or visibility on
6 that particular point.

7

8 Q. Let me take you back to the things you've said in your
9 statement. Perhaps we'll go back to basics: there's a
10 heads of agreement between the Commonwealth and Victoria
11 and the transition to NDIS has been phased.

12 A. Correct.

13

14 Q. There's a number of existing clients who are on
15 defined programs who are expected to transition to NDIS and
16 a number who have already. You said in your statement that
17 there is a transfer of funding between the state and the
18 Commonwealth. Can I get you to explain the transfer of
19 funds, we might start there, how has that arrangement
20 worked?

21 A. Essentially the NDIS is a Commonwealth initiative, and
22 the whole objective of it was to then essentially replace a
23 range of services provided by the states. So, as part of
24 the transition, funding is then provided to the
25 Commonwealth on those services and then the states then
26 step back from the provision of those services.

27

28 So, that's essentially what is happening in this
29 particular case, and the point that we discussed a couple
30 of minutes ago was, then dealing with those examples where
31 people may not be eligible for the NDIS but may have been
32 receiving state services and we've just got to sort through
33 and ensure that people aren't then slipping through the
34 cracks.

35

36 Q. That's what I'm asking you about. You've said in your
37 statement that:

38

39 "The Victorian Government is providing
40 funding continuity of support for clients
41 in defined programs who are not eligible
42 for the NDIS due to age or residency."

43

44 So, what's happening in that respect?

45 A. I probably need to take that on notice in terms of the
46 detail.

47

1 Q. Alright.

2 A. I'm more than happy to provide exactly what is
3 happening in terms of those arrangements, but that's part
4 of the Government's commitment, just to ensure that there
5 aren't people that slip through. But I'm happy to provide
6 the Commission with that additional information.

7

8 Q. Can I just give you this prompt: you've said:

9

10 "The Victorian Government has provided an
11 additional \$70 million across 2018/19 and
12 2019/20 to support Victoria's community
13 mental health sector during NDIS roll out.
14 This is separate from the \$77 million of
15 in-scope service delivery funding being
16 redirected to NDIS's clients transition.
17 It is to enable community mental health
18 organisations to retain workers and their
19 expertise during the transition, while
20 ensuring that clients assessed as eligible
21 for the NDIS receive the support they need
22 while awaiting transition to the NDIS."

23

24 A. Yes.

25

26 Q. So, those are the arrangements. We've heard evidence
27 in this Commission that, from the consumers' perspective,
28 they perceive themselves to be falling between the gaps;
29 and from the perspective of some services, it's reported
30 that they're not retaining workers and that their ability
31 to deliver services is being affected. So, those are the
32 gaps I think that the programs you're giving evidence about
33 are attempting to address.

34 A. Yeah.

35

36 Q. And I'm really asking you about how in practice
37 they're working?

38 A. So, it's hard for me to comment whether people are
39 slipping through the cracks, that's certainly not the
40 intent. As I note in the witness statement, the 77 relates
41 to the transfer and then in addition there's the
42 \$70 million the Government is providing, but I'm more than
43 happy to provide the Commission with whatever other
44 information my Department might have just to give a bit
45 more context in terms of the particular transfer.

46

47 Q. Alright, we might regard that as a question on notice

1 and we'll discuss that with the VGSO. Can I ask you about
2 the Commonwealth-State relationship to which you've alluded
3 a number of times: can you just say for context, what
4 aspects of the delivery of services by Victoria are funded
5 by the Commonwealth Government?

6 A. In terms of total quantity?

7
8 Q. Yes.

9 A. So, probably the best way to answer that is, the share
10 of revenue, total budget revenue that comes from the
11 Commonwealth, that's probably the best way to frame it. In
12 general terms, about half of the revenue in the state
13 budget arises from the Commonwealth, of which roughly half
14 of that is the GST and the other half comes from grants
15 from the Commonwealth. That's the rough - it varies a
16 little bit year-by-year but that's the rough order of
17 magnitude.

18
19 Q. If half is funded by the state and half is funded by
20 the Commonwealth, are there any constraints imposed by that
21 arrangement on the extent to which, when the Victorian
22 Government is looking to fund mental health services, are
23 there constraints on the capacity of the Victorian
24 Government to increase its funding by significant amounts
25 because the Commonwealth has to effectively match what
26 Victoria's going to do?

27 A. A couple of points I'd make. So, firstly, there's no
28 constraints on the GST that's provided to the states, the
29 states can spend that revenue as it sees fit. There are
30 generally constraints provided on grants for particular
31 purposes: so it might be on school funding, on health, on
32 an infrastructure project. There's not only constraints on
33 the purpose, but there could be constraints on how it's
34 actually spent. Essentially there's nothing embedded in
35 the system which would stop a state government deciding to
36 spend more of its own funding in a particular area.

37
38 Now, it's not surprising that state governments ask
39 for contributions from the Commonwealth, that occurs all
40 the time, but when that request is rejected, that doesn't
41 mean a state government can't proceed with spending more in
42 a particular area, so there's no real constraint there.

43
44 Q. In terms of further investments in mental health, what
45 do you see as the promise in developing bilateral
46 arrangements with the Commonwealth?

47 A. Sorry, the promise?

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Q. Yes, you mention in your statement that there are a number of both national partnerships and bilateral agreements, for example the bilateral agreement on national psychosocial support measures. So, if Victoria is to develop new initiatives, for example arising out of the Royal Commission, does Victoria see itself as being able to lead bilateral initiatives with the Commonwealth?

A. That would be the intent. Not surprisingly, a state government would want to partner the Commonwealth in a range of services, and if there can be not just funding but also other commitments, then that would be the ideal. So, those discussions, depending on where Royal Commission recommendations might get to, there would be no doubt extensive discussions between both governments on taking recommendations forward.

Q. Can you say something more about the NPA on supporting national mental health reform? You said that it:

"... sought to improve State and Territory mental health services, particularly in the priority areas of accommodation support and presentation, admission and discharge planning in emergency departments."

That's at paragraph 54 of your statement.

A. Along with general funding for the health system, there's a series of national partnership agreements which generally tend to be time-limited. So, there would be an agreement between the Commonwealth and the state - on the states - on funding for particular initiative that might end after three years. So, this particular national partnership agreement falls into that sort of category, and then those issues come up for then renegotiation and discussion between the two governments.

Q. Thank you. Can I ask you about the New Zealand Wellbeing Budget. Can you tell the Commissioners what you know about how that works and what its objectives are?

A. So, the Wellbeing Budget that they released in May of this year, it's quite an interesting document to read. Essentially, it does try and bring together what a number of governments tend to do in perhaps a not as explicit way. I guess the fundamental part of a Wellbeing Budget is recognition that the wellbeing of your citizens is much broader than just some key economic aggregates such as

1 economic growth: you know, it's the type of growth, what it
2 means for equity, the health of the citizens, those sorts
3 of things.
4

5 You don't necessarily need a Wellbeing Budget for
6 governments to make those statements, and governments often
7 do that, but in a sense the Wellbeing Budget starts off
8 with that principle, and then what they've done in
9 New Zealand is, essentially what they've described, setting
10 up domains, they've got I think 12 of them. Then the
11 important point is they as a Government have articulated
12 what they see as their priorities for the upcoming budget.
13

14 In the budget they released in May, they articulate
15 five, of which mental health is actually one of them. And,
16 without being part of their decision-making process but
17 what they've described publicly is, those priorities very
18 much determined how proposals that were brought forward for
19 consideration were assessed.
20

21 I read somewhere, in looking at the Wellbeing Budget,
22 that I think about half of the new initiatives in their
23 budget are directly tied to those five key priorities, and
24 the rest of it was really just about funding that is
25 necessary just to keep the business of government
26 proceeding.
27

28 So, that's really a key point about a Wellbeing Budget
29 in terms of recognition that, it's more than just growth,
30 and it's also about then articulating what your priorities
31 are and then assessing your proposals against that.
32

33 Now, governments generally do that in different ways.
34 It's not unusual for a Government at the start of a budget
35 process to say, well, our priority for this budget is these
36 particular areas, and we saw that under this Government
37 three years ago particularly around family violence.
38

39 The other important point I'd just make about the
40 Wellbeing Budget is, there's also quite a bit of emphasis
41 on then trying to connect services across Government, and
42 that's really I think a key part of their wellbeing
43 framework, and it comes back to my earlier comments about
44 more tailored service delivery around individuals. So,
45 they're placing quite a bit of emphasis on that.
46

47 And it's quite interesting, when you do look at their

1 budget papers, the other thing that sort of struck me is,
2 they do spend quite a bit of time in sort of explaining in
3 quite detail what the issues are they're trying to address
4 as part of those priorities, so there's quite a bit of
5 analysis included in their budget papers about each of the
6 priorities, dealing with that question of, why is it that
7 the Government wants to invest in those sort of areas. And
8 then their investments are not just about the immediate,
9 but it looks like a number of their investments are about,
10 how do you deal with the wellbeing of your citizens in the
11 long-term as well, so it's a bit of a combination.
12

13 So, it's an interesting document. We're - not unusual
14 for most Treasuries - quite interested in what happens in
15 other jurisdictions, so we keep a close eye on
16 developments, so we've actually had a bit of a look at what
17 they've done and whether there's anything we can learn from
18 that.
19

20 Q. Without wanting to commit you to it, knowing you can't
21 speak for the whole of government yourself, does Treasury
22 consider that there are some things that Victoria can learn
23 from the New Zealand Wellbeing Budget?

24 A. Well, certainly interesting aspects about, how you go
25 about assessing wellbeing and how you go about articulating
26 priorities. As I mentioned, governments often do those
27 sorts of elements anyway, but in perhaps a less explicit
28 way.
29

30 It's not unusual for governments to set priorities for
31 an upcoming budget and it's not unusual for governments to
32 recognise that it's not just about strong economic growth,
33 you need to deal with problems in your society. It really
34 just looks at trying to bring all those things together, so
35 we're certainly having a close look at it to see whether
36 there's any useful things that we can advise and brief
37 Government on in terms of how we can improve our budget and
38 our budget process.
39

40 Q. Is one of the most powerful things about that approach
41 to the budget the strong statement of priorities?

42 A. I think that is an important part of the whole funding
43 framework, because at the end of the day funding is
44 determined by the Government, they're the ones who make the
45 decisions, and the articulation of priorities really then
46 drives where the investment goes. We saw that, as I have
47 mentioned a couple of times, with this Government on family

1 violence: it was clearly a key priority for the Government
2 in that budget and it really then led quite a bit of the
3 decision making to end up with that quite significant
4 package of investment three budgets ago.

5
6 MS NICHOLS: Thank you, Mr Martine. Chair, do the
7 Commissioners have any questions?

8
9 CHAIR: Professor Fels.

10
11 COMMISSIONER FELLS: Q. Thank you for this excellently
12 set out account of your financing. Having given us the
13 ballpark on the Commonwealth 50 per cent or so of your
14 revenue, could you give us ballpark on the other sources of
15 revenue, stamp duty, et cetera, please?

16 A. I am talking now off the top of my head here. Stamp
17 duty is actually not as significant as what a lot of
18 commentators think. A couple of years ago it was at about
19 10 per cent of total revenue; I think it slipped a bit, so
20 it might be around 8 per cent, would be my rough guide.

21
22 Certainly in our budget papers there's quite detailed
23 charts that sort of split that out, but I think from memory
24 it's probably sitting at about roughly 8 per cent.

25
26 Q. And the others, carry on?

27 A. So, stamp duty; the next biggest tax line is payroll
28 tax. Then you go to annual land tax, which only applies to
29 investors and commercial properties, then you start
30 dropping away with other revenue lines such as gambling,
31 fees, fines, those sorts of things.

32
33 COMMISSIONER FELLS: Thank you.

34
35 THE CHAIR: Q. Thank you, Mr Martine. Can I ask just
36 one other question, it goes back to the issue about the
37 complexity of forecasting demand and need in mental health.
38 I guess this is one of the things this Royal Commission is
39 trying to grapple with, because mental health as part of a
40 health system doesn't seem to have had the same challenge
41 in identifying chronic health needs, other form of health
42 need.

43
44 And so, just coming back to that a little further, can
45 I just push you a bit more: is it more than just the issue
46 of unidentified and identified need that leads to that
47 complexity? Because, we're repeatedly told it's

1 particularly complex, and I must say, coming to terms with
2 why is still challenging.

3 A. And I think that's potentially the key point, is to
4 try and actually understand why, because clearly where we
5 are today indicates that it has been difficult to identify
6 what that demand need actually is; despite, as I mentioned
7 earlier, a very significant growth in funding over the last
8 roughly nine years, and even despite that 71 per cent
9 increase in funding, we're still not meeting demand.

10
11 So I think it's a very complex difficult area to
12 really get a good handle on, and there's no question that
13 one of the key priorities moving forward is to try and work
14 out the best way to forecast that demand; because, if we
15 can't do that, then a lot of the other issues that we're
16 looking at won't really matter, we've got to get a good
17 handle on that demand forecasting.

18
19 Q. If I just explore that a little bit further: at this
20 Royal Commission we've heard often and people have
21 described it as "the soft bigotry of low expectations", so
22 what happens when over a long period of time consumers stop
23 asking for help or stop going and demanding service because
24 they feel defeated by the lack of responsiveness.

25
26 When you think about how to quantify that is part of
27 the challenge, with a long period of time with inadequate
28 funding?

29 A. And that is very difficult, and I suspect that is a
30 real problem that's there, and that's really that
31 unidentified demand that I referred to earlier. So, it's
32 not just - there are measures that we probably have now
33 which identifies the existing demand that people appear,
34 but it's that unidentified bit that is going to be hard to
35 determine, which as additional funding is provided and
36 there's different ways of services being provided, you
37 would expect that some of that unidentified demand would
38 then start emerging. But trying to get a handle on what
39 that actually is won't be easy.

40
41 But as I indicated in one of my answers, the way the
42 demand funding generally works is that sort of annual
43 assessment in the budget where, particularly in the areas
44 of Health and Education, the demand needs are then
45 identified by the relevant Ministers for their
46 consideration.

1 So, it might be that, you know, it takes a period of
2 time just to try and get that better forecasting and
3 information in place; that might actually take a number
4 of years to get right.

5
6 Q. Can I also then take up one final issue which is the
7 issue of substitution. So, what we've heard is that many
8 times the inadequate response from the formal mental health
9 system places a particular burden on carers and families to
10 become the default service provider. Measuring something
11 like the contribution of carers in meeting or supporting
12 demand, how do you think we could go about doing that? And
13 are you aware of any examples where that's actually been
14 done successfully to convince governments about another
15 area of under-expense?

16 A. I can't think of any examples off the top of my head,
17 but it is a real issue about the interaction between
18 different areas of spending, and it's the sort of thing
19 that you do want to ensure gets identified as part of the
20 decision-making process: that, if a particular service is
21 not funded, the consequence of that might be funding
22 pressures elsewhere in the system, which might actually
23 relate to a completely different area of Government or a
24 particularly different output as well. So, I can't think
25 of any examples off the top of my head, but it is a real
26 issue.

27
28 Q. On that similar vein, some have suggested in the
29 course of this Royal Commission and our consultations, that
30 the limitations of the mental health system might mean that
31 you have an increasing number of people presenting in the
32 criminal justice system and ending up in prison, for
33 example, or the homeless population; so that's another area
34 of potential substitution; that if you had a more adequate
35 response, some of those people would be being managed in
36 the mental health system.

37 A. I agree, and that's all very important analysis as
38 part of essentially what I'd describe as a business case
39 going forward for particular funding, and quite a few of
40 those linkages are already recognised. How you go about
41 measuring is quite difficult and how you go about
42 accounting for those is quite difficult as well.

43
44 Q. So we may have to have further discussions with
45 Treasury in the course of this Royal Commission about how
46 some of that might be done?

47 A. Yes.

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CHAIR: Thank you.

MS NICHOLS: May Mr Martine be excused?

CHAIR: Yes, thank you very much for your witness statement and evidence today, Mr Martine.

<THE WITNESS WITHDREW

MS BATTEN: Thank you, Chair. I understand that there is a restricted publication order in relation to the next witness.

CHAIR: Pursuant to the Inquiries Act 2014, the Royal Commission has made an order that prohibits the publication of any information that might enable the identity of the next witness who will be referred to as the pseudonym, "Nina Edwards".

A copy of this order has been placed next to the door of the hearing room. The hearing of Nina Edwards' evidence will be limited to those people attending today's hearings. For those watching on the live stream, this portion of today's hearing will not be broadcasted. I ask that the live stream now be cut.

(Live stream cut.)

MS BATTEN: Thank you. I call Ms Nina Edwards.

<NINA EDWARDS, sworn and examined: [11.13am]

MS BATTEN: Thank you. Have you made a witness statement to the Royal Commission in the name of "Nina Edwards"?

A. Yes, I have.

Q. I tender that statement. [WIT.0001.0066.0001] Can you please start by telling the Commission why you are here to give evidence today?

A. Sure. So, the Royal Commission is a highly regarded process and, as a person who's had lived experience, I feel it important to share that. I also feel equipped to discuss my experience with a lens of longevity.

I started as being acutely unwell. I was a part of the missing middle for a couple of decades, and I have now

1 embarked upon recovery, so I have a full spectrum of
2 understanding of the system.

3
4 Q. Can we start from when you were 16, when you were
5 living in New South Wales, and can you tell the Commission
6 about your experience with the New South Wales mental
7 health system?

8 A. Sure. So, when I was 16, I started having panic
9 attacks: they were there more than they weren't there. I
10 wasn't sure where to go in terms of service provision,
11 pharmacotherapy or psychosocial support, so I went to a GP
12 as one does and I requested support around the symptoms
13 which I considered were a slow death; I didn't understand
14 what was happening.

15
16 The GP asked me if I wanted pharmacotherapy in the
17 form of antidepressants. I declined this and I went to see
18 a counsellor. This counsellor was not funded by Medicare.
19 So, I was living on \$218 a fortnight at the time, so I went
20 and saw the counsellor. I didn't find it very helpful
21 because they didn't have the depth and breadth of
22 understanding in terms of my illness. They gave me a book
23 to read called, "Learned Helplessness" and then asked me to
24 make an appointment if I so wished.

25
26 Q. Can you please try and describe what it was like for
27 you being trapped in a mental illness?

28 A. Yeah, sure. So, it was an extremely vivid and
29 heightened experience. I had anxiety and panic attacks
30 more days than I didn't, they were extremely debilitating
31 and I found it very difficult to attend school and to get
32 to school.

33
34 A lot of the time I would be too unwell to go to
35 school, so I had a lot of disciplinary interactions at
36 school because of my lack of attendance. Everything was
37 very difficult for me. I remember lying in bed at night
38 thinking that I was about to hit the ceiling literally
39 because my understanding of reality was very, very confused
40 and chaotic and it felt like I had left my body.

41
42 Q. You said that you felt ashamed and paranoid about
43 people learning about your altered reality: could you tell
44 us about that, please?

45 A. Sure. So, in high school a part of my peer group were
46 very high performing academic students; they came from very
47 comfortable middle-class backgrounds who did not appear to

1 have any problems, so in terms of my peers at the time, I
2 felt very isolated and there weren't avenues at school to
3 talk about it.

4
5 I also felt ashamed because I thought that panic
6 attacks only happened to homelessness people, and I was
7 always very ashamed when I faced people that they would see
8 me blushing and they would see me trying not to fall over
9 and induce a lack of respect on their part because of my
10 disintegrating mental state and inability to coherently
11 have conversations.

12
13 Q. You referred to going to see a GP and a counsellor; is
14 that how you managed your illness?

15 A. I think they were a very small part of the things that
16 I tried to do to be okay, so I would not describe that as a
17 big part of my experience.

18
19 Q. Can we move to when you were a university student; can
20 you please describe your mental health at that time?

21 A. Sure. So, I got into Uni on the basis of special
22 recommendation because I didn't pass Year 12 and, when I
23 got there, I felt like I was already two steps behind
24 because I didn't feel I had the academic integrity.

25
26 It was very difficult for me to concentrate on the
27 themes that I was studying, and I found it very difficult
28 to go to class. It was a really humiliating experience and
29 I did not feel like I belonged because of my mental
30 illness.

31
32 Q. What kind of supports did you have at this time?

33 A. So, I was living in various share homes with varieties
34 of support. The main support I had at the time was my best
35 friend who acted as an informal ad hoc support person. I
36 wasn't really engaged in family relationships at the time.
37 My lecturers were very supportive in that they consistently
38 argued for my show cause - that's when you're kicked out of
39 university because of fails - so, they were very
40 supportive.

41
42 Q. When you were about 22, you said that you were
43 couch-surfing and you were suicidal at that point, and you
44 took yourself to the ED in Sydney and you were hospitalised
45 for a week. Can you please tell the Commission about being
46 hospitalised?

47 A. Sure. So, I was suicidal from about the age of 17

1 onwards, I was periodically self-harming, and it reached a
2 head when I was 22. I was couch-surfing at the time and I
3 couldn't handle the intensity of the panic attacks or the
4 depression that had started to accompany my anxiety a
5 couple of years earlier. I knew that I had reached a
6 point at which I would either take my own life or I had to
7 engage in some sort of social infrastructure such as a
8 hospital.

9
10 Q. You've said in your statement that you were dependent
11 on the ED for 10 years.

12 A. Yep.

13
14 Q. Can you tell the Commission about your visits to the
15 ED?

16 A. Sure. So, not having any formal psychosocial
17 supports, or many informal supports due to my
18 self-isolating, I found the ED to be a place where I could
19 go because the chaos of the room there matched my inner
20 psychology, so it was really the only place where I felt
21 safe and the noise in my head was muffled.

22
23 I also found that the staff at the ED were as
24 accommodating as they could be given that they
25 self-identified - in my experience those people
26 self-identified as working in a [REDACTED], so they
27 weren't particularly happy, but they were pleasant enough.

28
29 An emergency clinical nurse practitioner engaged me
30 and this was the first time that I had spoken to a
31 practitioner or a psychosocial support worker to support
32 me. It was very much ad hoc, I would turn up whenever I
33 needed to, with variable success in terms of personal
34 support.

35
36 They would give me antipsychotics to reduce my slight
37 hallucinations and my anxiety and my depression, and the
38 emergency mental health nurse practitioner provided
39 psychosocial support, as well as a normalising influence as
40 to how I self-identified and experienced my mental illness.

41
42 Q. You also came down to Melbourne for a couple of months
43 at a time over a number of years; can you tell us about
44 your experience with the Melbourne mental health system in
45 those times?

46 A. Yeah, sure. So, my experience in Melbourne was seeing
47 GPs ad hoc in large medical centres that bulk billed; this

1 mirrored my previous experience interstate. When I told
2 them things like, "There are ants in my head, I'm seeing
3 nooses everywhere, I can't cope any more, I can't earn any
4 money, I can't do this", they wouldn't really engage. They
5 engaged in a clinical manner and they refilled my script
6 for antidepressants, which thus far were not very
7 appropriate for my mental illness, but they prescribed me
8 the inappropriate antidepressants, yeah.

9
10 Q. Then you moved to Victoria permanently in 2015, and
11 you have attributed a Melbourne GP with starting your
12 recovery: can you talk about what that GP did to start your
13 recovery?

14 A. Yes, sure. So, this was an ad hoc visit to a GP
15 medical centre. I engaged the GP with my, I guess,
16 unsophisticated understanding of what was happening. I was
17 still not aware of why my symptoms were so severe and I had
18 no formal diagnosis.

19
20 I started telling the GP that I was going to end my
21 life if the noises in my head and the drilling in my head
22 wouldn't stop. They took it very seriously and they told
23 me to speak as much as I like because they can extend my
24 visit into a triple visit, so that took the pressure off
25 the usual, I think, 7.25 minutes of seeing a GP.

26
27 He asked me about my symptoms and he engaged in a
28 thorough process of diagnostics and did particular tests
29 which give a tangible scale of one's symptoms, and he asked
30 me a lot of questions about what was happening in my head.

31
32 It was very difficult for me to explain because I was
33 in a self-perceived crisis where it was very hard to talk
34 because I felt like I was under water, on a rollercoaster,
35 with drilling going on in my head. I mention this so that
36 people can understand the depth of incapacity that myself
37 and other lived experience people have.

38
39 I felt like he engaged two-thirds of the way and I
40 engaged one-third of the way. He wasn't paternalistic, he
41 simply let me speak, and after about an hour he told me
42 that he understood that this was a crisis and he made sure
43 that he understood it was a crisis on my terms because, if
44 somebody's always in a crisis, it's not necessarily a
45 point at which they're in danger. But he understood that I
46 was in danger and he told me that he thinks I might have
47 bipolar or depression.

1
2 He then urged me to engage a clinical psychologist and
3 a psychiatrist as soon as possible, and he made sure that I
4 would let the reception staff know that I made an
5 appointment with a separate external service provider.
6

7 Q. You've made the point that he recognised the need to
8 engage with allied health services outside his own skill
9 sets and clinical discourse.

10 A. Yep.

11
12 Q. And that was important to your recovery?

13 A. That was very important because up to that point I had
14 engaged a couple of psychologists, but I - I had the
15 impression, and I still do, that clinicians and some
16 community workers don't refer on; so they very much work
17 within the paradigm of their own profession, and they use
18 the tools which they are equipped with. I don't think that
19 the psychologists I saw were able to identify the danger I
20 was in of ending my life because I presented articulately
21 and I presented possibly in a way that was indicative of
22 somebody who had social mobility, not the crawling ants in
23 one's head wreck that I actually was.
24

25 Q. Can I move to the topic of your work. You work in the
26 mental health system, and you've given in your statement
27 some examples of what you've seen people with mental or
28 psychosocial health issues doing to survive. Can you give
29 us some of those examples, please?

30 A. Sure. So, obviously I'm not here on behalf of an
31 organisation, I'm speaking from my perspective. I
32 currently work as a consumer in the mental health sector, I
33 work for a non-Government organisation, and my role is to
34 engage with people who are thinking of or they're actually
35 applying to participate in the NDIS.
36

37 A lot of the people that I speak to are actually
38 referred from the programs that are funded to support
39 people who are transitioning from, say, allied health or
40 psychosocial organisations, so they have too many people on
41 the waiting list, or some of these people don't feel
42 equipped to support their transition.
43

44 I just want to point out that, in my work, the
45 psychosocial services have got some very skilled workers;
46 however they are restricted for a number of reasons, which
47 is why they end up being referred to myself. Their funding

1 is now in six-month intervals while the state government
2 works out the needs of the transition.

3
4 So they come and see me, and a lot of these people
5 don't have very much knowledge about the NDIS. Some have
6 engaged a lot of services, some haven't engaged any. I
7 probably speak to about 15-20 people a week. Some of them
8 I'll spend up to eight hours with over a period of weeks;
9 other people it might be a 10 minute phone call.

10
11 Almost every day I get suicidal phone calls from
12 people who are really distressed about not having social
13 supports in place, or the fear of not having social
14 supports in place because the funding of these services are
15 finishing.

16
17 A lot of these suicidal calls are from people who
18 don't have the resources to pay for some of the evidence
19 that is required to enter into the new system and its
20 assessment process. Other people don't have the social
21 supports to support them through the process. Some people
22 might have very limited literacy or psychological coping
23 skills in order to deal with the process.

24
25 A lot of people that I speak to have - not dual
26 diagnosis, sorry - have multiple disabilities, so they
27 often engage in the process by using their sensory or
28 physical or cognitive disability as their primary reason
29 for accessing the new system, and they will almost always
30 try to put their psychosocial disability as a secondary
31 disability or not on there at all because there is so much
32 confusion about how to actually access the NDIS, in my
33 experience from what I've seen.

34
35 Q. Finally, can I turn to the topic of problems. Based
36 on your experience and your work, what do you see as some
37 of the problems with the Victorian mental health system?

38 A. Sure. So, one of the fundamental problems that I see
39 is the siloing of services. So, for example, in allied
40 health there might be different types of clinicians who can
41 support people in different ways. There might be different
42 psychosocial programs that can support people in different
43 ways.

44
45 When somebody goes out to engage these services,
46 there's no central point to which one can turn to
47 understand the spectrum of services there. This is

1 particularly critical when people lack either the mental
2 health to go about finding services, or they don't have any
3 informal social infrastructure in their lives.
4

5 Another problem is the affordability of the Victorian
6 mental health system. By the time I moved to Melbourne I
7 was able to have limited financial support from my family,
8 but on the whole I paid for my services myself. The
9 psychiatry appointments were \$220 out-of-pocket. The
10 psychology appointments limited to the 10 visits were about
11 \$140 out-of-pocket.
12

13 So, if you can imagine that somebody who has ants in
14 their head, who can't walk down the street because they're
15 so disoriented, who are feeling very, very suicidal, that
16 person might have to spend \$220 a week to see the
17 psychiatrist in order to sustain life. Life can be very,
18 very unsustainable if you don't have the support.
19

20 My particular experience has been engaging clinicians;
21 that's not to say that psychosocial supports aren't
22 incredibly important as well. I can only speak for myself,
23 so I don't speak about the paradigms of mental healthcare
24 per se.
25

26 MS BATTEN: Thank you very much. Chair, are there any
27 further questions for Ms Edwards?
28

29 CHAIR: Q. I guess you have touched very much upon the
30 issue of access to affordable stable housing too.

31 A. Yep.
32

33 Q. So, you describe in your long journey before you got
34 the help you needed, you were couch-surfing, you didn't
35 have somewhere easy to live. Can you just talk about that
36 and also from what you hear from your NDIS applicants about
37 the impact of lack of stable housing on your mental health?

38 A. Yep, sure. So, in terms of my own unstable housing up
39 until I was about 35, I would say that there is a two-way
40 interaction in terms of the situation I was in. My mental
41 health had deteriorated and was destabilised, so I could
42 not engage in enough work or work that paid enough to
43 actually do things like save up for rental bonds.
44

45 I remember once I had to move, so I actually waited
46 for a bond refund, put all my items in the front yard, and
47 then ran to the real estate to give this released bond to

1 another real estate so I could move.

2

3 The other thing is that, the lack of affordable and
4 safe and decent housing is really, really inadequate. So,
5 without that home base, one's mental health can easily
6 deteriorate.

7

8 In terms of my interactions with people who I work
9 with who are either trying to access the NDIS or are on the
10 NDIS, housing is a massive problem. A lot of people who
11 are still accessing either continuity of care or people who
12 are on the NDIS, are on public housing lists that are over
13 10 years and this adds to their suicidality.

14

15 I probably have this conversation with people once a
16 week at work. So, it's a two-way street: the economic
17 factors of our society and housing as a commodity means
18 that people can't find housing because of the lack of
19 rentals and the lack of affordability, and the issue of
20 mental health impacts people's ability to engage in
21 affordable housing.

22

23 CHAIR: Thank you very much.

24

25 MS BATTEN: Thank you. May Ms Edwards please be excused?

26

27 CHAIR: Yes. Thank you very much for your witness
28 statement and coming and sharing with us today.

29

30 <THE WITNESS WITHDREW

31

32 MS BATTEN: Chair, is now a convenient time for a morning
33 break?

34

35 CHAIR: Yes, thank you.

36

37 **SHORT ADJOURNMENT**

38

39 MS BATTEN: Commissioners, the next witness is Ms Julie
40 Dempsey. I call Julie.

41

42 <JULIE ANN DEMPSEY, affirmed and examined: [11.59am]

43

44 MS BATTEN: Q. Thank you, Julie. Have you, with the
45 assistance of the Royal Commission's lawyers, made a
46 witness statement for this Royal Commission?

47

A. Yes, I have.

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Q. I tender that statement. [WIT.0001.0067.0001] Julie, can we start by you telling the Commission why you have chosen to come and give evidence here today?

A. Yes, I've just written a brief bit. I'll read out from this:

"I would like to be here today as a symbol of hope for myself and others.

"On the weekend, whilst working on my evidence which has been quite traumatising, I treated myself to seeing the Apollo 11 documentary at IMAX. I was eight years old when the moon landing happened. I watched on the wooden school floor with a sense of awe and hope for the future.

"Space flight and science fiction become an interest for me and is to this day. Unfortunately my life after that was to be one of extreme distress, horror and alienation from society, friends and family.

"Watching the Saturn 5 rocket take off on Saturday night brought back to me that sense of awe and achievement.

"I do not take the luxury of these feelings for granted. I would not say I have come full circle. Illness is only ever a few serious stresses and sleepless nights away. You never get back to where you came from but I have defiantly and gratefully moved forward in my life to a new positive place."

Q. Thank you, Julie. We might go back to where it started, and can I take you back to when you were in fifth form at high school when you had your first psychotic breakdown. Can you please tell the Commission what was going on for you at that time?

A. I was under a lot of stress. My parents were going through a really difficult divorce. I had an identical twin sister who was starting to date boys and get more independent and move away from the close relationship we'd

1 always had with each other. I was going in a slightly
2 different direction to her as well. Yeah, they were the
3 main stressors in my life, and just the usual teenage
4 finding yourself problems we all grow up with.

5
6 Q. You've said that you spoke to a high school
7 counsellor, but you didn't really divulge a lot to them:
8 why didn't you divulge more to the counsellor?

9 A. Ever since my childhood, I had nightmares and fears of
10 being taken away and locked up, taken away from my friends
11 and family and locked away. I to this day don't know why I
12 always had those nightmares and it's ironic that I have
13 actually now been locked up and taken away literally, yeah.

14
15 Q. You've pulled yourself together in high school and
16 finished your Higher School Certificate and you were one
17 the top students in the state in English and you received
18 commendations in every subject. Then you started your
19 Bachelor of Arts at university and in your first year you
20 were the top of 400 students; is that right?

21 A. Yes, that's correct.

22
23 Q. And you achieved a number of high distinctions in your
24 first year?

25 A. Yes, every subject I had a high distinction in.

26
27 Q. Then in your second year you started Honours, but
28 halfway through that year, the second year, things did not
29 go well: can you tell us what happened at that point?

30 A. Right, I had my second major psychotic breakdown, this
31 one was more serious than the one I recovered from on my
32 own in high school. This one led to a hospital stay. I
33 went from being an involved student at Uni, taking in
34 everything I could intellectually and socially, taking
35 advantage of the environment, to going in and out of
36 hospitals and feeling like an outsider, not part of the
37 student community any more, and a bit of an intruder when
38 I'd go back and, really, it got to the stage where my main
39 connection with university was the student counselling
40 service and not much else.

41
42 Q. You said that at this point all these doors were
43 shutting around you and then your normal supports went away
44 and they were replaced by psychiatric system supports: what
45 were the psychiatric system supports like?

46 A. They could be quite cold and alienating. They weren't
47 like the warmth you'd get from a family member or a friend

1 supporting you through a crisis. They were much more
2 clinical and directed. A main type of support they used,
3 or their main type really I think is medication, and I've
4 had serious consequences with side-effects from medication,
5 and that started to transform how I looked physically, how
6 I saw my body image; I'd put on dramatic amounts of weight
7 and I couldn't get clothes to fit me properly any more, so
8 I looked more slovenly, if you like, and as people see a
9 typical psychiatric patient, there are reasons why people
10 present certain ways, it's not just because they couldn't
11 be bothered, and I actually took pride in the way I
12 dressed, even though I'd go and see a psychiatrist and
13 they'd say, "Can't you dress better?" And I thought, "I
14 am, I'm clean."

15
16 That's another thing, I don't want to be too critical
17 of psychiatrists, they've helped keep me alive, they have
18 to make some tough decisions to keep people here and
19 living, but they can make quite unilateral decisions at
20 times, and without much consultation with the rest of the
21 treating team, and I think that's something we need to be
22 wary of, and hopefully the new Mental Health Act has got
23 more protections around that, that ultimately I think
24 psychiatrists have the burden but also the privilege and
25 power of making ultimate decisions around people's lives.

26
27 Q. In this first hospitalisation after your psychosis in
28 second year Uni, you said that the unit was supposed to be
29 progressive but some things they did were quite cruel: can
30 you give us an example of something they did that was
31 cruel?

32 A. A couple of things come to mind straight away, one was
33 the relaxation class. It was taken by a psychologist and
34 everything was done in group programs back in those days,
35 so you had to live with your peers, your peer fellow
36 patients, and also expose your vulnerabilities, I guess.
37 We were asked to lie on the floor with our legs on a chair
38 to do relaxation and shut our eyes, and because of previous
39 abuse history I felt vulnerable doing that, so I crossed my
40 legs on the chair. He then proceeded to make an example
41 out of me and humiliate me for doing that. I thought
42 someone in that position should have more sensitivity and
43 guessed why I was crossing my legs instead of making fun of
44 me.

45
46 The other thing that comes to mind was - can you just
47 prompt me again on that one?

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Q. Yes. This was when the unit was cruel to you, and another example you gave was about the diagnosis, they wouldn't tell you about your diagnosis?

A. Yes. Back in those days they didn't always tell you your diagnosis straight up, and so, for two years I didn't know my diagnosis; I was led to believe I was extremely neurotic, and I was told I did not get psychotic and I needed to manage my mind better. How you do that, I don't know, I was totally out of control and going to them for help, and so I became very depressed as well as psychotic and living in a state of horror and fear, even though I was in a hospital, I wasn't getting support for what my symptoms were that mattered to me, because they were saying you're neurotic and need behaviour therapy, and that wasn't helping what was actually going on for me.

It wasn't until two years later when I was in a larger institution that one of the social workers, at great personal cost to her, broke ranks from the multidisciplinary team and said, "Julie, you actually get psychotic", and that just took so much guilt and shame off my shoulders. You never think someone would be glad to be told they're psychotic, but for me it lifted and explained a whole lot of things for me, and it was something I could start to work with and come to grips with instead of some airy-fairy, not controlling yourself idea.

Q. When you were in the inpatient unit, you were in there for nine months and then you were an outpatient for another year, and you've said for eight years you went back and forth between the hospital and university. Can you tell the Commission about the difficulties in doing that?

A. Yes, so I went backwards and forwards between multiple hospitals depending where I lived because it's zoned to area. Some of them were worse than others, they're not all exactly the same depending where you go.

I'd go back to university, do another subject, end up back in hospital, have to defer for the rest of the year, so this went on for eight years until I used up my eight years. I got within half a unit of actually finishing my degree. I don't know what kept me going because I was just so doped up and distracted by voices, it was really hard to concentrate in class, and I'd have to sleep on the benches in between the tutorial rooms, in between tutes to just try and be there and get to a class, so it became a

1 real struggle.

2

3 Writing essays used to be a joyful challenge, it
4 turned into this cognitive nightmare for me. I somehow got
5 the essays written and got to nearly get my degree, so it
6 was very frustrating to get so close and miss out in the
7 opportunity.

8

9 Q. Then you've said, ultimately you did get your degree?

10 A. Yes.

11

12 Q. And you were one unit short, but ultimately you did
13 get it: how did you get it?

14 A. That was thanks to another social worker I knew at a
15 rehab service, and I was talking to her one day about how
16 hard it was to see my friends and family around me all
17 getting degrees and getting into work, and I felt like a
18 nothing and a failure. And I'd had the world before me
19 when I was at first year Uni: I was planning on going into
20 lecturing, academia or law or social work. You know, it
21 wasn't just one path, I could have done multiple things and
22 all that shut down, and so - sorry, what was the question
23 again?

24

25 Q. About how you ultimately got your degree?

26 A. Yeah, so the social worker thought it was outrageous
27 that I didn't get my degree and knew how much it meant to
28 me, so she arranged a meeting with the dean and we went and
29 saw him and he said I was a brilliant student when he
30 looked up my notes. And then, rather bizarrely, they
31 agreed to give me my degree posthumously, and the Julie I
32 had known in the first year was well and truly gone, but it
33 was, in some ways it was sort of fitting. But anyway, I
34 went to the ceremony and I got my degree and it just
35 changed my life so much. It was a turning point for me in
36 that maybe I can make something of my life, maybe I do
37 matter, all of those years of struggle weren't just a waste
38 of time. So, yeah, it was really important for me to get
39 that recognition.

40

41 Q. You've said over the years you've had extensive ECT,
42 and that ECT was primarily against your will?

43 A. Yes.

44

45 Q. How did you have it if it was against your will?

46 A. I was certified, so I was put in a locked ward, I was
47 escorted to the ECT suite. I didn't actually physically

1 struggle; I just thought, well, there's no way out of this
2 and submitted. I'd come out of ECT with a splitting
3 headache, confusion, not sure where I was, I'd be wheeled
4 out in a wheelchair and you can have short-term memory loss
5 where you're not even sure whether you've had ECT, and the
6 whole thing is very confusing.

7
8 And, after you go through this process a number of
9 times your mind becomes quite battered, or mine did anyway,
10 and you start to submit anyway because you've just lost
11 your fight and you're so confused. You don't even know
12 your personal self any more; it doesn't just take away
13 things like memory and things like that, it takes away your
14 essential sense of being and soul almost for me; it's quite
15 devastating for me.

16
17 Q. You gave the example of you being a practising
18 Buddhist?

19 A. Yes.

20
21 Q. And then after your ECT, you no longer had that
22 memory. Can you tell the Commission about that?

23 A. Yeah, so last time I had extensive ECT I was a
24 practising Buddhist before I had it. I'd requested not to
25 have it, I said I was worried how it would affect me
26 cognitively. From history I knew it would take me two
27 years probably to get back to - I'd never get back to where
28 I was, but to get back to some sort of cognitive level.

29
30 And, I was meditating twice a day, I was in advanced
31 Karma classes, I had read extensively on the subject. I
32 had the ECT, I lost all memory about Buddhism, all the
33 teachings. I lost my sense of spirituality; that was
34 ripped from me. I have never been able to regain that
35 sense of spirituality.

36
37 I went back to Buddhism. The only reason I even
38 remembered I'd been Buddhist was because I went through
39 some books at home and thought, "What are these?" And saw
40 notes in the column and thought, "Oh, I've read these."
41 So, it was pretty shocking and demoralising. And, I've
42 tried to regain my spirituality, but it's just not there
43 any more, it's just theory to me now.

44
45 Q. You mentioned the side-effects of medication. You
46 were Olanzapine for 20 years with some disastrous physical
47 side-effects: can you tell the Commission about some of

1 those side-effects?

2 A. Well, I've actually got a long list here, and these
3 are typical for a lot of people, so a lot of people have to
4 put up with this. This is not just Olanzapine but a
5 variety of medications I've been on.

6

7 Eyesight disturbance, sedation, weight gaining,
8 increased appetite, high cholesterol, confusion, akathisia,
9 dry mouth, dental issues, constipation, diabetes, low blood
10 pressure, low motivation resulting in lack of exercise,
11 incontinence, asthma complications, clashing with other
12 medications, urinary retention, sex drive impairment,
13 severe untreated stomach reflux leading to precancerous
14 Barrett's mucosa, cognitive impairment, Parkinsonian-type
15 tremors, nausea, and a stomach ulcer to name a few.

16

17 Q. You repeatedly request a medication change which was
18 denied?

19 A. Yes.

20

21 Q. So, you on occasions tried to go off the medication by
22 yourself, and that resulted in traumatic hospital stays.
23 Can you please tell the Commission about the hospital
24 stays?

25 A. So, I'd become seriously unwell coming off the
26 medication and be certified and put in hospital, and I
27 would have willingly done it gradually in a measured way
28 and gone on to - I wasn't saying I wanted to come off all
29 medication, I would have gone on to a substitute, but they
30 said, "No, this is what suits you best, just put up with
31 it." It's almost like you've got to put up with these
32 sorts of side effects because this is your lot as a psych
33 patient and everyone does so you can too, and they forget
34 about the individual person and how it's affecting you as a
35 person.

36

37 I know mental illness needs to be controlled, if you
38 like, especially if you get violent or agitated, but there
39 has to be more to controlling it than the cost we are
40 paying in physical health. I don't expect to live to a
41 long age, I think it's 25 years younger than psych patients
42 can expect to die than the rest of the population. With my
43 health complications, I'm not expecting to live to an old
44 age so I'm just making the most of what I have now. Sorry,
45 what was the rest of your question?

46

47 Q. No, that's a response, Julie. Can I take you to the

1 issue of police interaction. You've referred to two
2 negative experiences with the police: the first was when
3 your partner, Kerrie, died in your home after taking an
4 overdose, and you've stated that you were treated brutally
5 by the police when they arrived. Can you please tell the
6 Commission about that experience?

7 A. Yeah, sure. So, I found Kerrie dead on the kitchen
8 floor, she'd killed herself while I was asleep. I knew she
9 was suicidal. She wasn't a psych patient as such, she was
10 actually working for the Government and was in a bit of
11 stress, and so, I was looking out for her and thought I
12 won't leave her alone and it just didn't occur to me she'd
13 do it while I was asleep; a mistake I regret to this day.
14

15 But anyway, the ambulance and fire brigade were there,
16 then they waited until the police came and then the
17 police - I was sitting on the floor holding Kerrie's hand,
18 and this police sergeant came in with a constable and said,
19 "Oh you, we want you to go to the bedroom." I said, "Why
20 do I have to go to the bedroom?" They said, "Because we
21 need to search for a suicide note." That didn't actually
22 exist, they never found one. I've looked to this day and
23 never found one. [REDACTED]
24 [REDACTED]
25 [REDACTED]
26 [REDACTED].
27

28 Q. We maybe won't encourage people to do that but remind
29 them of the supports that are available.

30 A. Yeah. But they sent me to my bedroom and they
31 searched the house while I was sitting alone in the
32 bedroom, no other supports or family had arrived as yet, it
33 had only been dead Kerrie, the police, fire brigade and the
34 ambulance, and they wouldn't even negotiate it, they said,
35 "We're not going to have any arguments about this, you just
36 go sit down there."
37

38 So, I'm in there with the door shut wondering what
39 they're finding, and feeling guilty and ashamed that I'm
40 somehow responsible for Kerrie's death and that they're
41 looking for some sort of evidence, and that I could be in
42 trouble myself.
43

44 Q. In contrast, how were you treated by the ambulance
45 officers?

46 A. The ambulance were lovely, they were very supportive.
47 As each of them left they touched my arm and said, "Sorry

1 for your loss", and that human connection at that time I
2 remember to this - this was 2002 - I remember clearly to
3 this day it meant so much to me, especially after what was
4 going to happen with the police, to have that sympathy and
5 just acknowledgment of the enormity of what had just
6 happened.

7
8 Q. You referred to two incidents involving the police:
9 the second one was when you were in the back of a divi van
10 which you've said was one of the lowest points of your
11 life. Can you please tell the Commissioners about that
12 experience?

13 A. Yes, I was in a hospital Emergency Department needing
14 transport to hospital, a psychiatric hospital. There were
15 no ambulances available so they decided to use a divi van.
16 I wasn't agitated or aggressive, why they couldn't take
17 me - you see these mass murderers and things being escorted
18 with dignity in between two police officers in the back of
19 a police car; I've never committed a crime in my life and
20 I'm thrown in the back of this divi van in front of a
21 waiting room full of people at the Emergency Department; it
22 was so degrading.

23
24 And, as you drive away, you see everything being
25 removed from you because everything's going backwards
26 because you're sitting backwards in the back of a divi van,
27 and that had to be one of the lowest points of my life, and
28 I think that was at the point that I really lost my
29 citizenship.

30
31 Q. Can I turn to the issue of rebuilding a meaningful
32 life. You've given a speech on rebuilding a meaningful
33 life and we've got a copy of that attached to your witness
34 statement. What have been the key things for you in
35 rebuilding a meaningful life?

36 A. So, there have been a number of things: a big one has
37 been hope as I spoke of at the beginning of my statement,
38 and other people held the hope for me when I couldn't any
39 more. For many years I felt so degraded by the system and
40 the illness, and I felt quite sub-human. I no longer even
41 acknowledge myself as a fit human being amongst my fellow
42 human beings; I was just subordinate as far as I was
43 concerned, and it was friends and family who said, "We can
44 still see Julie in there", even amongst all this despair
45 degradation I'd gone through. They held that hope, and
46 somehow the fact that they held hope for me somehow in all
47 that despair connected enough to keep me alive.

1
2 Then when I was ready to re-emerge, if you like, and
3 batter my way back up to the surface, I had that to pull on
4 and to cling to, and never underestimate how much a
5 friendly word or a bit of compassion can mean to someone
6 when they're desperate.
7

8 Q. You're now a senior consumer consultant at
9 Forensicare, and you've been at Forensicare since 2009?

10 A. M'mm.

11
12 Q. So what does your role as a senior consumer consultant
13 involve?

14 A. So, it's quite extensive, I cover the whole of
15 Forensicare services: community, prisons and Thomas Embling
16 Hospital. I guess the key thing I see in my role, it's
17 similar to social work roles, and we have an allyship model
18 there where we work together, is promoting and preserving
19 justice and human rights for patients.
20

21 And so, within the psychiatric system I think the
22 Mental Health Act trumps all other Acts. I know it
23 certainly overrides the Victorian Charter of Human Rights
24 and the UN Charter of Human Rights, and that's pretty
25 powerful legislation, and so, I try to look out and empower
26 patients and consumers to know what their rights are, to be
27 able to stand up for themselves, to hold the service
28 accountable and to get the best service delivery for the
29 patients, but also to work with clinicians and management
30 so they understand consumer perspective, and they can make
31 the best the service can be as well.
32

33 Q. You've also referred to mentoring various patients and
34 colleagues including senior clinical staff. Why do you
35 mentor people?

36 A. I think I mentor people for that justice reason: I
37 don't want anyone else to have to go through what I've been
38 through over the years. If I can change anything for
39 anyone out of what I've been through, then that's worth
40 doing and I figure, without being self-pompous or anything,
41 I think if I can do it - because I was down there with
42 horrible psychosis and negative symptoms for decades; I was
43 a lost cause. Many people - I think the system even gave
44 up on me, it was just individual people who kept me going
45 and kept supporting me: so, if I can do it, I hope anyone
46 can do it.
47

1 Q. You've held various executive roles at Women's Mental
2 Health Network Victoria, including being the Chairperson,
3 and you've also received three awards for your work in
4 mental health. I'm going to read what those three awards
5 are and then I'll ask you a question at the end.

6
7 The first one was in 2014, you received Minister for
8 Health's Victorian Public Healthcare Award for outstanding
9 achievement by an individual or team in mental
10 Healthcare. In October 2018, the Thomas Embling Consumer
11 Advisory Group won the Consumer Advisory Group Award at the
12 Victorian Mental Illness Awareness Council. In May
13 this year you were awarded the 2019 Meritorious Service
14 Award by the Victorian branch of the Royal Australian and
15 New Zealand College of Psychiatry.

16
17 My question is, what has receiving these awards meant
18 for you?

19 A. It's made me feel proud of myself. So, I've gone from
20 a level of sub-human up to, I don't wanna get a big head,
21 you know, and I hopefully still fit through doors. Yeah,
22 no, it's made me proud of myself and it's not a hollow
23 proudness. Those awards are hard fought and won, and
24 there's something my colleagues can recognise in that
25 beyond - so many times you get seen as a psychiatric
26 patient first and a person second, and hopefully with those
27 awards - my fellow consumers always congratulate me and
28 said, "Well done", but hopefully colleagues can see that
29 there's something to recognise there beyond someone dealing
30 with symptoms.

31
32 Q. I'm going to ask if we could have a slide that shows
33 some of your artwork. [WIT.0001.0067.0016] Can you please
34 tell the Commissioners about how you use art for coping
35 when you're seriously unwell?

36 A. So, I use art as a method of communication around what
37 is happening for me. When you're in psychosis and extreme
38 distress, it can be really hard to translate that in words
39 across to someone who hasn't been through it or to a
40 practitioner, and the artwork also is a therapeutic tool
41 for me to exorcise my demons, if you like, get them out on
42 paper out of my head. And then when I'm well, also I can
43 look back and see where I was and think about how did I get
44 out of that and what can I do in future.

45
46 So this example is, I went on an art outing with a
47 rehab service, and this was after my last ECT lots, and I

1 was quite depressed and thought there's no hope for me, I
2 couldn't even be bothered going on the outing, I just got
3 pressured into it. And while we were there, the art
4 teacher helped me to see art and drawing in a more artistic
5 way, so it was a different way of looking at the world: to
6 look at the outline of the tree I wanted to draw and the
7 light and dark, instead of just looking at this tree and
8 trying to draw it, and that was a revelation for me.

9
10 As you see, "Julie sees bigger picture". I went from
11 this naked, exposed, desperate person who was just about
12 ready to give up the ghost, to this clothed, more secure
13 happy person, child-like on a swing with the future in
14 front of them.

15
16 Q. Can I turn to the issue of the mental health system
17 and reform. I want to ask you about a number of different
18 topics. The first is the Mental Health Act. So, you've
19 said in your statement that:

20
21 "The implementation of the Mental Health
22 Act 2014 held much promise, however the
23 underpinning recovery principles and
24 general consumer participatory nature of
25 the Act have been limited in uptake. The
26 culture of the mental health system
27 essentially hasn't changed."

28
29 Can you expand on that and tell the Commissioners what
30 you mean by that?

31 A. I think the ideas behind the Mental Health Act around
32 capacity and supported decision-making instead of
33 substituted decision-making, and recognising person-centred
34 care, I think they're all great ideals to have in it.
35 However, from my observations of - I haven't actually been
36 in hospital myself recently, but I work in the field and I
37 have friends who go into hospital, and from what I've
38 spoken to them about, it's not clear that this is being
39 taken up as well as it should be by the services. It's
40 really hard to change this ingrained negative culture we
41 have in the psychiatric system.

42
43 I'm not blanketing everyone with that, we have stand
44 out individuals and nurses, psychiatrists, psychiatric
45 service officers, people throughout the system who mentor
46 and are a great example and relationship builder with
47 patients and can make a tremendous difference to your life.

1 But we also have a negative, desensitised, overworked,
2 stressed out workforce that can't see the light for the
3 trees sometimes and I think that comes across in their
4 practice.

5
6 A key example of that is, going back to when I was in
7 Larundel years ago, the nurses would stay on the floor all
8 day with you, they'd engage with you, they'd keep your mind
9 active, they didn't just leave you to your own misery in a
10 corner somewhere and not engage and try and help you
11 practically through what was going on for you.

12
13 Today the nurses have a lot of paperwork to do, they
14 tend to stay in the nurses station a lot and not out on the
15 floor, and then there's this thing about, it's not safe;
16 you hear the reports in the news, it's not safe in the
17 psychiatric system for staff and the unions all get
18 involved. Well, how can it be safe if it's so "us and
19 them". You're leaving the consumers to struggle in an
20 acute state where they could be delusional and have
21 paranoia and fearful and that can build up.

22
23 If you're on the floor engaging with them and building
24 some sort of therapeutic relationship, you could actually
25 defuse a lot of that, defuse the need for seclusion. I've
26 been put in seclusion so many times and I wasn't even
27 agitated to start with, they just wanted to give me an
28 injection that I was refusing. I'd get surrounded by
29 people in blue gloves and a kidney dish with a needle in
30 it. Next thing you know you're being dragged off and
31 forcibly injected and held down with a knee in your back,
32 and you've got some security guard watching you who you see
33 down the local shops watching you be stripped naked and put
34 in pyjamas. How can you preserve any sort of dignity in
35 that situation and how can you build up relationships? You
36 can't.

37
38 Q. Another area that you are passionate about is gender
39 issues, and you've given a talk at North East Victoria
40 Innovative Learning on your experience of inpatient
41 psychiatric wards and the gender-specific problems in the
42 mental health arena. Can you identify some of those
43 problems?

44 A. The problem with mixed sex wards is extensive, it's
45 long running from back into the 1960s when they introduced
46 mixed sex wards. From my personal experience, when I'd go
47 and give talks at forums, at conferences about

1 gender-sensitive issues and what we can do to help
2 alleviate them and to training for staff, and I could go on
3 all day about the issues, but just a few examples of what I
4 experienced in a hospital stay is: male patients walking
5 naked from the shower out into the day room, not being
6 reprimanded by nurses for doing it, just saying, "Go get a
7 towel."
8

9 If a female patient was to do that - well, they
10 wouldn't do that - but if they were a bit promiscuous,
11 they'd get put in HDU for their protection. I've been
12 sitting on a lounge and have a male patient next to me
13 expose himself, I've had another male patient start playing
14 with himself. Sorry, these are a bit abrupt but this is
15 the reality you are facing when you're an inpatient.
16

17 I've had friends who have been raped and have since
18 committed suicide because there wasn't proper follow up
19 support. We don't even have a dedicated system with CASA
20 for alleged sexual assaults where they are automatically
21 called in. These are basic things that services have been
22 told to do for years by concerned clinicians, consumers,
23 carers, and it's just not happening; they're just - I don't
24 know if they're not listening, if they're not capable of -
25 everything's siloed. I don't know if they're not capable
26 of communicating and connecting with other services, but
27 the system itself is imploding and other possible supports
28 out in the community aren't accessed.
29

30 Q. Can I turn to the issue of lived experience workforce.
31 You've said that:

32
33 "We need peer-run respite and drop in
34 services, similar in model to VMIAC, that
35 is, run for consumers by consumers."
36

37 Can you tell the Commission how you think the lived
38 experience workforce needs to be reformed?

39 A. I think we need extensively more peer workers in the
40 system itself. They've proven, with the post-discharge
41 program that's rolled out over the last few years, it's
42 proven so beneficial where they're introduced into services
43 by DHHS, that those services have now used their own
44 funding to create more positions, so I think we need to
45 extend that.
46

47 I think we need to extend other positions in services,

1 like psychiatric service officers who are on the ground
2 engaging with patients, they give practical supports, they
3 can be great mentors. We need more social workers in the
4 system. It's too medically top-heavy. There are so many
5 other workers we could employ to be more holistic in our
6 care to consumers than just sticking so rigidly to a
7 medical model that has proven alienating, cold and
8 ineffective.

9
10 Q. The final idea for reform that you had was a dedicated
11 media unit?

12 A. Yeah.

13
14 Q. Can you tell us about that idea?

15 A. So, I think we need - there is so much negative press
16 and stigma about mental illness and psychiatric patients,
17 that I think we need a dedicated unit a bit like in
18 Australia's StigmaWatch but going a step further, and that
19 is, if there's negative reports in the media, then
20 following them up and not letting the media get away with
21 it and saying, this isn't accurate, you've portrayed this
22 person in a negative light. I'm not saying the state
23 should direct everything, but encourage them to do a more
24 positive follow-up story. To get out there - we need
25 advertising and campaigns to get out there positive stories
26 of consumer experiences.

27
28 And not just recovery stories, but negative ones, so
29 people are aware of what consumers are facing. It's not
30 just when you go into hospital that you need attention; to
31 get into hospital you have to be homicidal and suicidal
32 combined I reckon, you have to be so acute to get service:
33 what about all the time in between when we could be
34 preventing these crises and giving some maintenance and
35 helping people learn about their symptoms and how to deal
36 with them? There's no maintenance out there, there's no
37 support in between actual super-crisis, and for some
38 people, like for decades I was chronic, I was actively
39 psychotic all the time, what support is there?

40
41 I had my partner, Kerrie, she unfortunately passed
42 away, and that again was a burden on her as a carer; after
43 that it was just repeated hospital stay after stay for me.

44
45 Q. Thank you, Julie. Is there anything else that you
46 would like to say to the Commission at this point?

47 A. Yeah, I've just got something I'd like to finish with:

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"We are all someone else's someone else. Mental illness does not discriminate and neither should we. We need to share the struggle together, not push consumers to the fringe of common social existence. The system needs radical change, not more band-aid solutions:

"To make this happen serious funding needs to be allocated. If we can do it for railway crossings that are dangerous and inconvenient, we can do it for distressed, vulnerable and to some extent forgotten people.

"With the right systems and supports in place we can make hope for meaningful life achievable and real. Please return some humanity to this crisis-driven system to allow for meaningful rehabilitation and prevention, not just abrupt medication adjustments and fleeting contact with support staff.

"Staff also need to see the fruits of their practice instead of only seeing people at their worst and in crisis. We are all patients and staff struggling and drowning in this broken system. Please construct something new that encompasses the best of humanity, not the dregs of despair."

Thank you very much.

MS BATTEN: Thank you, Julie. Chair, are there any further questions for Julie?

CHAIR: I don't think so, Julie, I don't think we could ask anything more. So, thank you very much for coming and sharing your reflections with us today and for your witness statement.

MS BATTEN: Thank you. May Julie please be excused?

CHAIR: Yes.

1 <THE WITNESS WITHDREW

2

3 MS BATTEN: Chair, that concludes the evidence for today
4 and this hearing.

5

6 CHAIR: Today marks the final day of the Royal
7 Commission's four weeks of public hearings. It has been a
8 powerful month, moving and inspiring. We have heard from a
9 range of witnesses at the Melbourne Town Hall, in
10 Maryborough and at the Aborigines Advancement League in
11 Thornbury. This has included 29 people living with
12 challenges to their mental health, carers and family
13 members, and 67 mental health professionals, CEOs,
14 academics and public servants.

15

16 We have heard from a breadth of consumer perspectives,
17 from young people, to those who have lived through
18 institutionalisation, from Aboriginal Elders, to farmers,
19 to politicians, to refugees and footballers.

20

21 We have gained insights from school principals, police
22 officers, paramedics, sector leaders, clinicians and
23 researchers.

24

25 With deep gratitude, we thank everyone who has
26 participated in these hearings.

27

28 In particular, we thank the community witnesses who
29 have shared their personal experiences. We understand that
30 it is not easy to retell private and painful experiences,
31 particularly with a wide audience.

32

33 We acknowledge the time and effort it takes to
34 prepare, combat nerves, and appear in front of the
35 Commission. We have been struck by people's openness and
36 purpose in an environment that can at times feel
37 intimidating.

38

39 We have been moved by the humanity that was palpable
40 throughout the hearings. We saw witnesses form bonds,
41 reach out to one another, offer support and share hope.

42

43 Everyone has demonstrated a commitment to making
44 things better so that others may avoid a similar path. In
45 the words of one witness, "If I can help one person, that's
46 a win. That's all that matters to me, is to give back."
47 We give our thanks to you all.

1
2 We have also heard from mental health professionals,
3 academics, CEOs and public servants. Their contributions
4 spanned the systemic challenges with Victoria's mental
5 health services and, along with the community witnesses,
6 generated ideas for reform. We are grateful to all these
7 witnesses for sharing their expertise, insights and time.
8

9 Each witness has put in an enormous amount of care and
10 concern into their evidence, and each witness, no matter
11 their background, demonstrated a collective commitment to
12 making the mental health system better.
13

14 Each contribution shared with the Commission will be
15 critical to our work. Each contribution will inform our
16 deliberations and proposed reforms and will assist us in
17 understanding the impact of policy and system design.
18

19 This month has re-affirmed how mental health
20 conditions can touch anyone from any walk of life, people
21 on different paths with different opportunities, from all
22 different backgrounds.
23

24 We heard that stigma can be experienced differently
25 across the mental health continuum. Its impact can prevent
26 people reaching out and seeking help. People experience
27 discrimination, particularly in the workplace, and are
28 impeded from living full and contributing lives.
29

30 We were welcomed at the Aborigines Advancement League,
31 as we continue to learn from the wisdom and build on the
32 knowledge of Aboriginal Victorians. We heard about the
33 critical importance of Aboriginal-led responses and
34 culturally appropriate services; how difficult it is for an
35 Aboriginal person to talk about their experiences when the
36 person in front of them has no understanding of Aboriginal
37 culture and social and emotional wellbeing.
38

39 Witnesses conveyed the importance of understanding
40 that Aboriginal conceptions of mental health are holistic,
41 shaped by connections to culture, land, extended kinship,
42 ancestors and spirituality.
43

44 Throughout the weeks we have heard how important
45 networks are - families, friends, communities - to build
46 connections and support. We heard how important the basics
47 are - a home, health services, employment - to live well.

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We heard about the importance of inclusive services that are responsive to and reflecting of our diverse communities. As one witness said, "communities have their own ways to heal and it is important to build on that."

We heard how examples of stigma can be compounded by racism and intolerance. A stark example was the impact of racism on the mental health of Aboriginal people and how this can perpetuate a lack of self-worth carried from childhood and creating an additional stressor on mental health.

An Aboriginal Elder conveyed how her childhood experiences of racism were still raw, referring to her experiences as "a mental anguish you continually carry with you".

A young witness reflected on how racism and discrimination contributed to mental health challenges in diverse communities. He reflected on how common these experiences are in day-to-day life, saying how people cross the road when they see an African person or call the police because African people are in the local park.

We heard of the additional challenges people from the LGBTIQ community face and fear, when coming out may result in people being excluded from family, friends and social networks. As one witness said, "You could lose all of the connectors and protective factors that protect us around suicide."

We were moved by the experience of carers: young people caring for their parents and siblings, and parents navigating a fragmented system determined to find support. We were stirred by the honesty of families and carers as they talked of their commitment, as well as the exhaustion, the desperation and the fear of losing their loved ones.

Across the weeks we have consistently heard about the challenges people face in accessing services: people being turned away, being told they're not sick enough or being told there are no available beds.

As one witness described, "the mental health system felt like opening a door and seeing a yawning abyss. We opened the door and there was nothing behind it, absolutely

1 nothing."

2

3 Time and again we've heard of "the missing middle" and
4 the strain this places on services, culminating in people
5 spending days in emergency departments or people
6 experiencing suicidal ideation, being sent home to fend for
7 themselves and an increasing reliance on a police response.

8

9 For rural and regional communities, we heard about the
10 "tyranny of distance" people face as they try to access
11 services. We heard of one mother's struggle to receive
12 support for her child, where she packed up half her home,
13 quit her job and moved to Melbourne.

14

15 We heard of the challenges farmers face, including the
16 strain of running a business at the mercy of the
17 environment, social isolation, acclimatisation to risky
18 behaviours, and practical barriers to leaving the farm for
19 a day.

20

21 As one witness said, "farmers seem to put up with
22 injury so long as they can still actively farm and it is
23 only when they are unable to physically work that they will
24 eventually seek help."

25

26 We have heard about men who are reluctant to seek help
27 and fear being labelled as "weak".

28

29 In this short closing statement, I cannot do justice
30 to all the contributions we have heard in the past month.
31 But I must emphasise that we, the Commissioners, have been
32 deeply moved, sometimes overcome, by the honesty in which
33 people shared their experiences and expertise.

34

35 We have been inspired by the strength of people with
36 lived experience. Despite the failures of the mental
37 health system, we have seen people forge contributing and
38 fulfilling lives, many championing for reform. As one
39 witness said, "we are not passive, we will no longer
40 receive, we participate."

41

42 These hearings were all about ideas for reform.
43 Community witnesses, mental health professionals,
44 academics, public servants and CEOs shared their rich
45 insights and expertise, inspiring us to look forward and
46 envisage a mental health system for the future.

47

1 We must bring open minds to new ways of working. We
2 must consider the opportunities in our modern world, new
3 technologies, digital opportunities, if we are to envisage
4 a contemporary system.

5
6 We know that reform is not only about money. It will
7 take a coordinated effort, with long-term planning and
8 systems integration. It will involve a service response
9 and a community response.

10
11 We appreciate that there is a tension between building
12 on existing foundations and envisaging an entirely new
13 system. We will reflect on the contributions provided and
14 take a whole-of-system view.

15
16 We are mindful that band-aid solutions create
17 fragmentation and short-lived reform. A saying shared by
18 one witness resonated with us, "we have a lot of airports
19 around, that's because there's a lot of pilot projects that
20 come in and go."

21
22 We know that we cannot bring about reform without the
23 support of the workforce. We need to build on its strength
24 to lead change, influence culture, and drive reform.
25 Emerging leaders need to be encouraged to be open to new
26 ideas and to drive clinical excellence, and the peer
27 workforce must continue to exert influence.

28
29 Finally, across the weeks there has been a sense of
30 hope. We know that people have participated in and closely
31 followed these hearings because they believe in the purpose
32 of this Royal Commission. Perhaps for the first time some
33 people feel positive about the future of mental health
34 services.

35
36 We have heard your plea. We have heard that we must
37 be brave, bold and ambitious in our reforms. We must think
38 laterally, we must be open to new ideas, and we must be
39 future-focused.

40
41 As one mother implored, "please do everything you can
42 to prevent any parent having to deal with the enormous
43 aftermath of losing a child to suicide."

44
45 We feel the weight of responsibility in undertaking
46 this work, but we don't shy away from this challenge. We
47 know what is at stake and we will work hard to generate

1 change.

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1 our witnesses and those in attendance. This extends to the
2 Commission staff and indeed the Commissioners, and for this
3 service we are very grateful.
4

5 We thank Counsel Assisting: Lisa Nichols QC, Fiona
6 Batten and Georgina Coghlan and members of the legal team
7 in their preparation for the hearings and for their
8 dedicated and sensitive work throughout.
9

10 We thank the representatives of the media who have
11 attended the hearings and who have reported on the
12 proceedings in a respectful and caring way.
13

14 We acknowledge that many members of the public have
15 followed our public hearings. A number of people have been
16 here with us on multiple days or have listened to the live
17 stream or read the transcripts, sharing this experience
18 with us.
19

20 We are heartened by the broad interest in these
21 hearings and the sustained interest from the media and the
22 community. We believe the volume of public discourse is
23 reflective of the community's desire for change. We hope
24 it signals the community's willingness and openness to have
25 an honest conversation about mental health conditions and
26 to back significant reform.
27

28 Importantly, what has been captured in the public
29 discourse is people's personal experiences, voices that
30 have not been heard before.
31

32 We hope the public discourse continues to build and we
33 continue to be unified in our common purpose for change,
34 knowing that more of the same is simply not good enough.
35 This truly is a shared challenge and we all have a part to
36 play.
37

38 And finally, to those who have shared their personal
39 experiences, here and at the consultations, and in the
40 submissions, we thank you. Your voices are central to our
41 deliberations and will not be ignored.
42

43 Thank you.
44

45 **AT 12.55PM THE COMMISSION ADJOURNED**
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47

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