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

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

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

MS NICHOLS: Q. Mr Martine, are you the Secretary of the Department of Treasury and Finance in Victoria?
A. Yes, that is correct.

Q. Have you had that role since 2014?
A. Yes.

Q. Prior to that, did you have a number of senior roles in the Commonwealth public sector, including Deputy Secretary of the Commonwealth Department of Finance and Deregulation?
A. That is correct.

Q. And General Manager of Budget and Policy in the Commonwealth Treasury?
A. Yes.

Q. Have you prepared a statement on the subject of funding, including funding for mental health in the state of Victoria?
A. Yes, I have.

Q. I tender the statement. [WIT.0003.0005.0001] Mr Martine, can I ask you about the devolved governance model for budgeting and reporting that we have in Victoria. We have a devolved governance system in which departments manage global budgets that are designed around the delivery of agreed outputs aligned to Department objectives. Can you tell the Commissioners briefly, within that system governed by the various pieces of legislation and so on, what are the mechanisms for ensuring accountability in relation to the Victorian people receiving good value for money invested and appropriate investment?
A. Okay. We have what we call a resource management framework which, as you've described, is essentially a devolved system of output budgeting. But in a devolved system there are certain mechanisms to ensure transparency --

Q. I might just ask you to speak closer to the microphone if you would, thank you.
A. So we have a system that is a devolved system, but

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

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

Q. Can I ask you a fairly high level question about accountability. What are the fundamental objectives of the accountability regime as you describe it, from a policy perspective?
A. I guess, the accountability framework, in a sense, probably serves a couple of purposes. There's certainly an important purpose within Government in terms of providing the necessary information for the key decision-makers within Government to ensure that outputs are being delivered effectively and efficiently, and there's also the important public role in that accountability as well which involve certain reports to Parliament which might involve the actual budget papers each year, along with departmental annual reports is the other main mechanism that departments report on their output performance.

Q. Who is the decision-maker in relation to the amount of funding that gets given for the purposes of mental health each year?
A. Essentially, the key decision-maker, or the mechanism for making those decisions, is essentially the Expenditure Review Committee of the Cabinet. Now, those mechanisms vary according to governments, but the current Government has an Expenditure Review Committee of Cabinet and that's essentially the key decision-maker on all funding decisions, including on mental health.

Q. We'll get to outputs in a minute, but they're supposed to be aligned to departmental objectives, are they not?
A. That's correct.

Q. Who determines departmental objectives?
A. So, departmental objectives are put together by departments, they're approved by the relevant portfolio Minister, and they then have to be agreed by the Assistant Treasurer, and my Department in that process then provides advice to the Assistant Treasurer.

Q. What's the process for assessing the appropriateness of departmental objectives beyond the level of the Department?
A. So, the process: they would come forward from the portfolio Minister to my Department, and I have an area within my Department that is essentially mirroring the rest of Government, it sort of shadows, so I have a health team for example, and they would go through and assess the objectives, objective indicators and performance measures, and then they'd be providing advice to the Assistant Treasurer for his approval.

Q. So, within the context of the current framework a Department has a global budget: is there a mechanism for overseeing or scrutinising the Department's decisions to allocate funds within that global budget?
A. There is, and there's probably a couple of important points I would like to make. So, we do have a devolved system, however within the framework, as necessary, there can be certain restrictions or requirements imposed by Government.

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

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

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

Services are significantly above the amount of funding that they receive. There's a lot of detail behind that, but if you take that as a premise, what would be the mechanisms within Government to look at that as a problem and work out how to solve it? Is it just a matter of budgets coming up to Treasury, or business cases coming up to Treasury each year, or is there a higher level at which that sort of question is examined from Government's perspective?
A. Generally, most funding decisions are considered in the budget process, and the reason why that occurs is, it enables the Government of the day to assess relative priority, so that's generally the time that funding decisions are made - not in all situations - and in that context a portfolio Minister would be bringing forward a proposal. In a situation that you described, where there are demand pressures or unfunded pressures, that would be a key element of their business case that would be brought forward for consideration by the Expenditure Review Committee, and my Department, along with the Department of Premier and Cabinet, would be assessing those proposals and providing advice to the Committee.

Q. Is the baseline on which that is done the business case that's put up by the Department?
A. The business case is certainly an important part of consideration of the proposal, but it's not the only bit of information that's taken into account. So, we would, in assessing a particular proposal, be drawing on other reviews or reports that might exist, or just experience that policy advisors may have built up over time, so it's a matter of bringing all the information together to provide the right sort of advice to the Committee.

Q. In this model, the Department sets prices, is that right, that services are paid?
A. Generally, yes, but it depends a bit on the nature of the output and the nature of the delivery and, as I mentioned earlier, there are situations where Government naturally wants to have a proper detailed discussion about delivery, so they might actually have quite explicit decisions coming out of the Expenditure Review Committee about price, delivery, they might even relate to situations such as location of delivery services. Sometimes you may have an example where a decision is made to provide funding but the relevant Minister might be asked to come back in six months' time with a detailed implementation plan which might include pricing and other elements for the Committee

to actually endorse.

Q. There is now a Chief Financial Officer in each Department that reports directly to you, is that right?
A. That's correct. All departments have always had a Chief Financial Officer, but one of the election commitments that the Government had back in November was to have all Chief Financial Officers now report to myself.

Q. In the Department of Health and Human Services, specifically in relation to mental health, what do you expect of the role of that person?
A. So, the Department of Health and Human Services has a single Chief Financial Officer which covers the whole breadth of the Department.

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

Q. So that's transparency within Government going upwards?
A. That's correct.

Q. To use a specific example, the Commission's heard quite some evidence about disparity in resourcing between catchments, particularly in relation to growth corridors, who seem under-resourced compared with their population growth and by reference to the burden of mental ill-health. A question like that which is systematic, who in that matrix of people would look at that outside in response to a particular business case?
A. So, it could be a combination of either the Department through their Minister raises that as a particular issue that Government needs to address, or it could come from either my Department or the Department of Premier and Cabinet in assessing a proposal, giving advice to the Committee that might give different options or ways forward to actually spend a particular amount of money.

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

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

Q. Can you say what you mean by that in that context, the effectiveness question?
A. It's all about, what's the most effective way to deal with the particular problem that has been brought forward to the Committee to consider.

Q. What about the question of the transparency of how Area Mental Health Services are funded? This Commission's heard evidence that, from their perspective, they don't get transparency about funding decisions and why certain services are funded, apparently, at a different level than others. Is that a question simply for the Department or does it involve your Department as well?
A. Certainly we as a Department and within Government would get access to some transparency. In terms of the relationship that the Department of Health and Human Services might have with some of the service providers is probably a bit difficult for me to comment on.

Q. Yes, that's a matter for the Department of Health and Human Services, would you say?
A. Generally, yes, but as I mentioned earlier, there are situations where, depending on the nature of the service delivery, governments may actually get quite involved in the detail of how it's actually going to be delivered, and in that context there could be quite a bit of detail and transparency about where funding would be provided and to which providers.

Q. Could you provide an example of the kind of situation you're alluding to now?
A. Perhaps a good example, and this is going back a couple of budgets, is family violence. So, the Government had made family violence a major funding priority three budgets ago, and I think from memory in that budget there was an allocation of I think about $1.9 billion over four years, so it was a very big package. In the context of the development of that package, there were quite detailed discussions about both the scale of the investment, but also delivery, and there was also discussions about mechanisms to ensure that those initiatives are then delivered over a period of time.

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

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

Q. So, is the essential point that, provided an issue is a sufficient priority at the Government level, there is a considerable amount of latitude for ensuring that the correct objectives are met and met properly and efficiently?
A. Certainly the resource management framework, I believe, is flexible enough to accommodate a range of requirements and, if Government makes a particular area a priority, they can, under the existing framework, put in place a whole series of delivery requirements and accountability requirements, and none of those are inconsistent with the framework; they do work side-by-side and there's been numerous examples of those.

Q. Thank you. This Commission's heard considerable evidence that the Department has very limited capacity, or still has rather, a limited capacity to do detailed population-based planning and has significant data-gathering and assessing inadequacies, and that's in the context of there being a very significant gap between supply and demand. Are those sorts of systematic issues capable of being adequately addressed through the existing devolved governance funding model?
A. I think they are. Forecasting demand is quite complex, and it all comes down to ensuring you've got the right sort of data, but I don't see any of that inconsistent with the current funding model at all.

Q. What are the mechanisms within the current model for addressing underlying and chronic problems of a gap between supply and demand that are putting extraordinary pressures on the mental health system?
A. So, most demand pressures from a funding point of view are considered by Government through the budget process. So, where a particular area of Government spending - and generally they fall into two portfolios: Health and Education, they're the two areas that are generally driven by demand pressures.

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

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

Q. Can I return to the question of output funding: can you give an example of an output in mental health?
A. Essentially, there's the large mental health output which I think from memory is about $1.6 billion. In total there's $1.7 billion spent.

Q. So, from Treasury's perspective, an output is an outlay of money, but in relation to what the Department delivers in return for that funding, what are the measures of what it delivers? What's an example of an output in that context?
A. Well, the funding is provided at the output level, and each output would then have a series of performance measures against that output, which generally fall into the categories of quantity, quality and timeliness.

Q. Who determines the output measures?
A. So, they're brought forward by the relevant portfolio Minister for approval by the Assistant Treasurer, and my Department in that process would assess the performance measures in discussions with the relevant departments, and provide them feedback and then give advice to the Assistant Treasurer, but they do need to be agreed jointly by the portfolio Minister and the Assistant Treasurer.

Q. Within that process, what measures exist to ensure that the output measures are capable of identifying and meeting questions of demand and gaps between supply and demand in the mental health system?
A. So, often in terms of demand pressures, you would probably see those issues manifest themselves probably in two ways in the performance measures. Firstly, in some of the quantity performance measures depending on how they're structured, and then secondly demand pressures could very well flow through to what you see in actuals against targets for, for example, timeliness measures.

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

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

"Performance measures for clinical care output include quantity measures such as the annual number of clinical inpatient separations, and occupied residential subacute bed days, as well as quality and timeliness measures such as the number of designated mental health services achieving or maintaining accreditation ...", and so on.

Do you have that paragraph there, Mr Martine

A. I do.

Q. You go on to say that:

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

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

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

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

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

Q. Are you able to say what has happened in the case of this particular non-conformance with the performance measure?
A. I'd probably have to --

Q. I appreciate that is a question without notice.
A. Yeah, I'd probably have to take that on notice to provide any further details. It is acknowledged in Budget Paper No.3, p.208, there's a brief explanation of why the target wasn't achieved. The question of what was then done about trying to address that is something I'd have to take on notice, because it's something that I'd need to check.

Q. Alright, we might take that off-line, noting that as a question on notice. But would you expect, as a matter of process, where there is a non-conformance like that one which is in the context of there being not a great deal of performance output measures, that that would be followed up in terms of why it hasn't been met and what steps are going to be taken for it to be met in the next cycle?
A. I do, and a part of the performance management framework is we provide an assessment to the Assistant Treasurer twice a year and he takes that forward to Government for consideration.

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

Q. I see. Would you accept that the capacity of the Government at the level of Treasury and the Expenditure Review Committee to determine whether the mental health system is actually meeting demand and meeting the mental health needs of Victorians very much depends upon the adequacy of the performance output measures?
A. They're certainly very important to be able to assess delivery, there's no question about that.

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

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

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

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

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

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

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

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

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

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

Do you accept that that's been a longstanding problem and, if so, what do you think can be done about it?
A. Well, there's probably two parts I think to your question: one is, population in general for Victoria which, as I accept, we have underestimated that growth. And, it is hard to forecast population. We are forecasting a bit of a drop off in population based on the evidence we have, but whether that will eventuate is hard to tell.

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

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

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

Can I ask you to return to my question with that background about why it is that there's been a chronic underinvestment in mental health: is it a question of Government prioritisation, do you think?
A. That's always part of it. As I answered in one of your questions, at the end of the day all funding flows from Government decisions in a constrained fiscal environment. There's all a constraint on what can be spent, and so, governments need to then assess relative priorities.

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

Q. In circumstances where, because of the state of the mental health system, investment may be required that is of an order of magnitude greater than that already existing in order to fix the system, how will the current model of funding manage that, do you think?
A. Well, that issue will obviously need to be then considered by the Government through the normal budget process, but generally there's only three ways that governments can pay for things: you either cut spending in another area to fund more spending in a particular area; you either raise taxes to fund something, or you increase borrowing, so it's essentially one of those three, but those matters would need to be considered by the Government

through a budget process.

Q. In the context of the most recent budget, for 2019, the allocation for mental health was 42 per cent above that allowed in 2014/15. What were the factors in your assessment, without revealing privileged information, that allowed for a very substantial increase in funding to mental health?
A. Well, probably the last three budgets there's been reasonably significant additional allocations to mental health, particularly last year's budget: it was $587 million over four. This year's budget certainly less, but in a way not particularly surprising given the Mental Health Royal Commission is underway and it's not an unusual thing for governments to wait for outcomes before allocating some additional funding.

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

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

Q. Thank you. Can I ask you a little bit more about outcomes-based funding and the moves away from it potentially. You have discussed in your statement the challenges, I suppose, that outcomes-based funding pose. What are the issues related to the measurements of outcomes that Treasury needs to grapple with in mental health?
A. I'll assume that the question largely relates, not so much to outputs but outcomes?

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

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

Q. So, is there a need to link the outputs year-on-year with the longer term outcome measures?
A. Yes. So, the whole purpose of the framework is, it builds up from the bottom, so the outputs need to feed through to the objectives. There's no point having an output that's not delivering on a Government objective.

Q. In terms of the potential for changing funding models in relation to mental health, the question of activity-based funding has been on the agenda for a long period of time, but mental health has been largely stuck with block funding. In your assessment, what's been the reason for the long period of time that it's taken to reassess?
A. I think it comes down to the complexity of activity-based funding in an area such as mental health. And I preface my answer with the fact that I'm not an expert clinician, but in a whole range of areas in health, particularly in the sort of physical injury, the definition of an activity I think is a little bit more certain. Because for activity-based funding to work, you've got to identify the activity and then price it.

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

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

Q. We'll turn to alternative funding models shortly, but it is now accepted, isn't it, that there are a significant number of difficulties with block funding and that there's a desire to move away from it?
A. Generally, that is correct, and we as the Department do support that. There are situations where block funding is relevant. So, for example, in the current system for very small hospitals in Regional Victoria we use block

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

Q. You've said in your statement that DTF plays an important role in supporting Government to explore innovative ways in funding, including in the context of outcomes-based funding and you have mentioned Partnerships Addressing Disadvantage: can you say what those are?
A. So, there's been a couple of initiatives that have been led by my Department in terms of looking at different ways of delivering Government services. The Partnerships Addressing Disadvantage which we're currently developing is really an extension of two social impact bonds that we were responsible for establishing, and they've been announced and they're now just underway.

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

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

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

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

better way of delivering services.

Q. Can I get you to say a little bit more about that. So, in that context, how would the funding work? Does the funding follow the individual?
A. Generally it can, and NDIS is perhaps a good example where the model is around building up a package for an individual. So, there'd be a bucket of money provided for a suite of services, but then there's more discretion around how that funding is actually spent, and it's more targeted for what the individual actually needs, and that's where you get the enhanced effectiveness from that particular model.

Q. To what extent has that potential model been considered at Treasury level?
A. So, we would consider that as part of our assessment of proposals that come forward, and proposals do from time to time come forward; they're a little bit more centred around individuals. And, perhaps I should just add, it's not just about individuals; sometimes you may focus on locations, for example. So, you might, rather than have generic programs, you might target it a bit more to a particular location, or it might sit in between which might be a particular cohort. There are different sort of models, but the general point there is, having programs a little bit more targeted can improve effectiveness of what's actually provided.

Q. Has this been considered for a whole-of-system roll out, or is it just an idea that is being contemplated or piloted in relation to a smaller aspect of the mental health system?
A. Well, I think the Government submission talks a bit about moving more in that direction on mental health, so I think there's a movement: it's not, you know, big scale, but there's movement at the moment down that path.

Q. The extent to which Partnerships Addressing Disadvantage, what is the extent to which that could be rolled out in different areas across the mental health system? Do you think it's limited, for example, to the provision of psychosocial supports or something broader than that?
A. You'd have to look at the circumstances, but there's no reason why a number of those particular delivery models couldn't at least be examined as part of whether that's a

better way of delivering services.

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

Q. Can I ask you about the NDIS and your evidence about the eligibility criteria and the work that Treasury is doing in relation to the restrictive criteria that apply currently under the scheme?
A. So, most of our work and responsibility for the NDIS essentially relates to the interaction with the Commonwealth particularly around what it means for funding.

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

> "Ensuring that the NDIS responds to the needs of people with mental illness and psychosocial disability is a further area of discussion with the Commonwealth. This could include reviewing how eligibility criteria recognise the unique needs of people with a mental illness given the episodic nature of mental illness ...", and so on.

Is that an area you're identifying as having potential for discussion between Victoria and the Commonwealth?
A. Correct, and that's really relevant to one of my earlier points about where you've got two levels of Government, and really the point there is, for those people who fall just below the eligibility criteria, there's an important discussion that both jurisdictions need to have about how they are actually treated so that they just don't slip through the cracks.

Q. Can I ask you about the support, the continuation of support that's being provided for people in the transition phase to the NDIS?
A. Yes. So, there is some support that's provided for transition.

Q. How does that work on a practical level?

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

Q. Alright.
A. I probably don't have that knowledge or visibility on that particular point.

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

Q. There's a number of existing clients who are on defined programs who are expected to transition to NDIS and a number who have already. You said in your statement that there is a transfer of funding between the state and the Commonwealth. Can I get you to explain the transfer of funds, we might start there, how has that arrangement worked?
A. Essentially the NDIS is a Commonwealth initiative, and the whole objective of it was to then essentially replace a range of services provided by the states. So, as part of the transition, funding is then provided to the Commonwealth on those services and then the states then step back from the provision of those services.

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

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

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

So, what's happening in that respect?
A. I probably need to take that on notice in terms of the detail.

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

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

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

A. Yes.

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

Q. And I'm really asking you about how in practice they're working?
A. So, it's hard for me to comment whether people are slipping through the cracks, that's certainly not the intent. As I note in the witness statement, the 77 relates to the transfer and then in addition there's the $70 million the Government is providing, but I'm more than happy to provide the Commission with whatever other information my Department might have just to give a bit more context in terms of the particular transfer.

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

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

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

Q. If half is funded by the state and half is funded by the Commonwealth, are there any constraints imposed by that arrangement on the extent to which, when the Victorian Government is looking to fund mental health services, are there constraints on the capacity of the Victorian Government to increase its funding by significant amounts because the Commonwealth has to effectively match what Victoria's going to do?
A. A couple of points I'd make. So, firstly, there's no constraints on the GST that's provided to the states, the states can spend that revenue as it sees fit. There are generally constraints provided on grants for particular purposes: so it might be on school funding, on health, on an infrastructure project. There's not only constraints on the purpose, but there could be constraints on how it's actually spent. Essentially there's nothing embedded in the system which would stop a state government deciding to spend more of its own funding in a particular area.

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Without wanting to commit you to it, knowing you can't speak for the whole of government yourself, does Treasury consider that there are some things that Victoria can learn from the New Zealand Wellbeing Budget?
A. Well, certainly interesting aspects about, how you go about assessing wellbeing and how you go about articulating priorities. As I mentioned, governments often do those sorts of elements anyway, but in perhaps a less explicit way.

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

Q. Is one of the most powerful things about that approach to the budget the strong statement of priorities?
A. I think that is an important part of the whole funding framework, because at the end of the day funding is determined by the Government, they're the ones who make the decisions, and the articulation of priorities really then drives where the investment goes. We saw that, as I have mentioned a couple of times, with this Government on family

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

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

CHAIR: Professor Fels.

COMMISSIONER FELS: Q. Thank you for this excellently set out account of your financing. Having given us the ballpark on the Commonwealth 50 per cent or so of your revenue, could you give us ballpark on the other sources of revenue, stamp duty, et cetera, please?
A. I am talking now off the top of my head here. Stamp duty is actually not as significant as what a lot of commentators think. A couple of years ago it was at about 10 per cent of total revenue; I think it slipped a bit, so it might be around 8 per cent, would be my rough guide.

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

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

COMMISSIONER FELS: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

Q. Can we start from when you were 16, when you were living in New South Wales, and can you tell the Commission about your experience with the New South Wales mental health system?
A. Sure. So, when I was 16, I started having panic attacks: they were there more than they weren't there. I wasn't sure where to go in terms of service provision, pharmacotherapy or psychosocial support, so I went to a GP as one does and I requested support around the symptoms which I considered were a slow death; I didn't understand what was happening.

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

Q. Can you please try and describe what it was like for you being trapped in a mental illness?
A. Yeah, sure. So, it was an extremely vivid and heightened experience. I had anxiety and panic attacks more days than I didn't, they were extremely debilitating and I found it very difficult to attend school and to get to school.

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

Q. You said that you felt ashamed and paranoid about people learning about your altered reality: could you tell us about that, please?
A. Sure. So, in high school a part of my peer group were very high performing academic students; they came from very comfortable middle-class backgrounds who did not appear to

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

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

Q. You referred to going to see a GP and a counsellor; is that how you managed your illness?
A. I think they were a very small part of the things that I tried to do to be okay, so I would not describe that as a big part of my experience.

Q. Can we move to when you were a university student; can you please describe your mental health at that time?
A. Sure. So, I got into Uni on the basis of special recommendation because I didn't pass Year 12 and, when I got there, I felt like I was already two steps behind because I didn't feel I had the academic integrity.

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

Q. What kind of supports did you have at this time?
A. So, I was living in various share homes with varieties of support. The main support I had at the time was my best friend who acted as an informal ad hoc support person. I wasn't really engaged in family relationships at the time. My lecturers were very supportive in that they consistently argued for my show cause - that's when you're kicked out of university because of fails - so, they were very supportive.

Q. When you were about 22, you said that you were couch-surfing and you were suicidal at that point, and you took yourself to the ED in Sydney and you were hospitalised for a week. Can you please tell the Commission about being hospitalised?
A. Sure. So, I was suicidal from about the age of 17

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

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

Q. Can you tell the Commission about your visits to the ED?
A. Sure. So, not having any formal psychosocial supports, or many informal supports due to my self-isolating, I found the ED to be a place where I could go because the chaos of the room there matched my inner psychology, so it was really the only place where I felt safe and the noise in my head was muffled.

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

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

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

Q. You also came down to Melbourne for a couple of months at a time over a number of years; can you tell us about your experience with the Melbourne mental health system in those times?
A. Yeah, sure. So, my experience in Melbourne was seeing GPs ad hoc in large medical centres that bulk billed; this

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

Q. Then you moved to Victoria permanently in 2015, and you have attributed a Melbourne GP with starting your recovery: can you talk about what that GP did to start your recovery?
A. Yes, sure. So, this was an ad hoc visit to a GP medical centre. I engaged the GP with my, I guess, unsophisticated understanding of what was happening. I was still not aware of why my symptoms were so severe and I had no formal diagnosis.

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

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

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

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

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

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

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

Q. Can I move to the topic of your work. You work in the mental health system, and you've given in your statement some examples of what you've seen people with mental or psychosocial health issues doing to survive. Can you give us some of those examples, please?
A. Sure. So, obviously I'm not here on behalf of an organisation, I'm speaking from my perspective. I currently work as a consumer in the mental health sector, I work for a non-Government organisation, and my role is to engage with people who are thinking of or they're actually applying to participate in the NDIS.

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

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

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

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

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

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

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

Q. Finally, can I turn to the topic of problems. Based on your experience and your work, what do you see as some of the problems with the Victorian mental health system?
A. Sure. So, one of the fundamental problems that I see is the siloing of services. So, for example, in allied health there might be different types of clinicians who can support people in different ways. There might be different psychosocial programs that can support people in different ways.

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

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

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

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

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

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

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

Q. So, you describe in your long journey before you got the help you needed, you were couch-surfing, you didn't have somewhere easy to live. Can you just talk about that and also from what you hear from your NDIS applicants about the impact of lack of stable housing on your mental health?
A. Yep, sure. So, in terms of my own unstable housing up until I was about 35, I would say that there is a two-way interaction in terms of the situation I was in. My mental health had deteriorated and was destabilised, so I could not engage in enough work or work that paid enough to actually do things like save up for rental bonds.

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

another real estate so I could move.

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

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

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

CHAIR: Thank you very much.

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

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

<**THE WITNESS WITHDREW**

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

CHAIR: Yes, thank you.

SHORT ADJOURNMENT

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

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

MS BATTEN: Q. Thank you, Julie. Have you, with the assistance of the Royal Commission's lawyers, made a witness statement for this Royal Commission?
A. Yes, I have.

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

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

Q. You've said that you spoke to a high school counsellor, but you didn't really divulge a lot to them: why didn't you divulge more to the counsellor?
A. Ever since my childhood, I had nightmares and fears of being taken away and locked up, taken away from my friends and family and locked away. I to this day don't know why I always had those nightmares and it's ironic that I have actually now been locked up and taken away literally, yeah.

Q. You've pulled yourself together in high school and finished your Higher School Certificate and you were one the top students in the state in English and you received commendations in every subject. Then you started your Bachelor of Arts at university and in your first year you were the top of 400 students; is that right?
A. Yes, that's correct.

Q. And you achieved a number of high distinctions in your first year?
A. Yes, every subject I had a high distinction in.

Q. Then in your second year you started Honours, but halfway through that year, the second year, things did not go well: can you tell us what happened at that point?
A. Right, I had my second major psychotic breakdown, this one was more serious than the one I recovered from on my own in high school. This one led to a hospital stay. I went from being an involved student at Uni, taking in everything I could intellectually and socially, taking advantage of the environment, to going in and out of hospitals and feeling like an outsider, not part of the student community any more, and a bit of an intruder when I'd go back and, really, it got to the stage where my main connection with university was the student counselling service and not much else.

Q. You said that at this point all these doors were shutting around you and then your normal supports went away and they were replaced by psychiatric system supports: what were the psychiatric system supports like?
A. They could be quite cold and alienating. They weren't like the warmth you'd get from a family member or a friend

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

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

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

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

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

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

real struggle.

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

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

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

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

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

Q. How did you have it if it was against your will?
A. I was certified, so I was put in a locked ward, I was escorted to the ECT suite. I didn't actually physically

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

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

Q. You gave the example of you being a practising Buddhist?
A. Yes.

Q. And then after your ECT, you no longer had that memory. Can you tell the Commission about that?
A. Yeah, so last time I had extensive ECT I was a practising Buddhist before I had it. I'd requested not to have it, I said I was worried how it would affect me cognitively. From history I knew it would take me two years probably to get back to - I'd never get back to where I was, but to get back to some sort of cognitive level.

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

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

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

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

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

Q. You repeatedly request a medication change which was denied?
A. Yes.

Q. So, you on occasions tried to go off the medication by yourself, and that resulted in traumatic hospital stays. Can you please tell the Commission about the hospital stays?
A. So, I'd become seriously unwell coming off the medication and be certified and put in hospital, and I would have willingly done it gradually in a measured way and gone on to - I wasn't saying I wanted to come off all medication, I would have gone on to a substitute, but they said, "No, this is what suits you best, just put up with it." It's almost like you've got to put up with these sorts of side effects because this is your lot as a psych patient and everyone does so you can too, and they forget about the individual person and how it's affecting you as a person.

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

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

issue of police interaction. You've referred to two negative experiences with the police: the first was when your partner, Kerrie, died in your home after taking an overdose, and you've stated that you were treated brutally by the police when they arrived. Can you please tell the Commission about that experience?
A. Yeah, sure. So, I found Kerrie dead on the kitchen floor, she'd killed herself while I was asleep. I knew she was suicidal. She wasn't a psych patient as such, she was actually working for the Government and was in a bit of stress, and so, I was looking out for her and thought I won't leave her alone and it just didn't occur to me she'd do it while I was asleep; a mistake I regret to this day.

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

Q. We maybe won't encourage people to do that but remind them of the supports that are available.
A. Yeah. But they sent me to my bedroom and they searched the house while I was sitting alone in the bedroom, no other supports or family had arrived as yet, it had only been dead Kerrie, the police, fire brigade and the ambulance, and they wouldn't even negotiate it, they said, "We're not going to have any arguments about this, you just go sit down there."

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

Q. In contrast, how were you treated by the ambulance officers?
A. The ambulance were lovely, they were very supportive. As each of them left they touched my arm and said, "Sorry

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

Q. You referred to two incidents involving the police: the second one was when you were in the back of a divi van which you've said was one of the lowest points of your life. Can you please tell the Commissioners about that experience?
A. Yes, I was in a hospital Emergency Department needing transport to hospital, a psychiatric hospital. There were no ambulances available so they decided to use a divi van. I wasn't agitated or aggressive, why they couldn't take me - you see these mass murderers and things being escorted with dignity in between two police officers in the back of a police car; I've never committed a crime in my life and I'm thrown in the back of this divi van in front of a waiting room full of people at the Emergency Department; it was so degrading.

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

Q. Can I turn to the issue of rebuilding a meaningful life. You've given a speech on rebuilding a meaningful life and we've got a copy of that attached to your witness statement. What have been the key things for you in rebuilding a meaningful life?
A. So, there have been a number of things: a big one has been hope as I spoke of at the beginning of my statement, and other people held the hope for me when I couldn't any more. For many years I felt so degraded by the system and the illness, and I felt quite sub-human. I no longer even acknowledge myself as a fit human being amongst my fellow human beings; I was just subordinate as far as I was concerned, and it was friends and family who said, "We can still see Julie in there", even amongst all this despair degradation I'd gone through. They held that hope, and somehow the fact that they held hope for me somehow in all that despair connected enough to keep me alive.

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

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

Q. So what does your role as a senior consumer consultant involve?
A. So, it's quite extensive, I cover the whole of Forensicare services: community, prisons and Thomas Embling Hospital. I guess the key thing I see in my role, it's similar to social work roles, and we have an allyship model there where we work together, is promoting and preserving justice and human rights for patients.

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

Q. You've also referred to mentoring various patients and colleagues including senior clinical staff. Why do you mentor people?
A. I think I mentor people for that justice reason: I don't want anyone else to have to go through what I've been through over the years. If I can change anything for anyone out of what I've been through, then that's worth doing and I figure, without being self-pompous or anything, I think if I can do it - because I was down there with horrible psychosis and negative symptoms for decades; I was a lost cause. Many people - I think the system even gave up on me, it was just individual people who kept me going and kept supporting me: so, if I can do it, I hope anyone can do it.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> "We need peer-run respite and drop in services, similar in model to VMIAC, that is, run for consumers by consumers."

Can you tell the Commission how you think the lived experience workforce needs to be reformed?
A. I think we need extensively more peer workers in the system itself. They've proven, with the post-discharge program that's rolled out over the last few years, it's proven so beneficial where they're introduced into services by DHHS, that those services have now used their own funding to create more positions, so I think we need to extend that.

I think we need to extend other positions in services,

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

Q. The final idea for reform that you had was a dedicated media unit?
A. Yeah.

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

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

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

Q. Thank you, Julie. Is there anything else that you would like to stay to the Commission at this point?
A. Yeah, I've just got something I'd like to finish with:

"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.

<**THE WITNESS WITHDREW**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

nothing."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

change.

The Commissioners will now reflect on, examine and test the evidence we have heard, as we work towards our findings. We will continue to review the thousands of submissions and comments we have received, along with what we have heard across the community consultations with over 1,600 people. We will also consider a survey we undertook last month with 3,000 Victorians to understand the broader community's perceptions of mental health conditions.

The public hearings have been an important source of evidence, serving as another input to inform the range of issues that have been put forward for us to consider and help narrow our focus. We will undertake a careful and deliberative process and think deeply about the evidence raised and the information provided to us.

We will further consider issues through targeted engagement, research, hearings, roundtables, discussions with our Expert Advisory Committee, leading thinkers and researchers, and we will look here and abroad for new and emerging best-practice models in both mental health and parallel systems.

The Commission will provide an interim report to the Victorian Government by the end of November this year, followed by our final report in October 2020.

We have our work cut out for us, but there is no greater, more pressing challenge than realising the hope that has been ever-present across our work so far.

The evidence from the hearings, with the exception of the contributions that are subject to restricted publications orders, is accessible through the transcripts and witness statements that are available on the Commission's website.

Before rising, we would like to thank a number of people who have ensured these hearings run smoothly: the Commission staff, the transcribers, the technical supports and the support services.

Just as we encourage anyone who has been impacted by what they've heard to seek help or support, we have had a dedicated team of counsellors with us each day to support

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

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

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

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

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

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

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

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

Thank you.

AT 12.55PM THE COMMISSION ADJOURNED

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