MENTAL HEALTH ADVISORY COUNCIL MEETING MINUTES May 12, 2022

Attendees	Paul Parfitt (PP), Tracey Young (TY), Richard Oades (RO), Emily Wilding (EW), Pauline Cole (PCole), Virginia Catterall (VC), Jennifer Wilton (JW), Nafiso Mohamed (NM), Lee Steel (LS)	Mental Health Commission Djeran Room, Level 1, 1 Nash Street Perth WA 6004 and MS Teams Thursday, 12 May 2022 08:30am – 12:30pm
Chair	Margaret Doherty (MD)	
Deputy Chair	Patricia Councillor (PC)	
MHC Support	Caitlin Parry, Project Officer System Development, MHC Larissa Barnao, Administration Support Officer System Development, MHC	
Guests	Ms Amanda Waegeli, Consumer Representative MHEC and CMC Ms Kerry Hawkins, Carer Representative MHEC and CMC	
Apologies	Jessica Nguyen	
AGENDA ITEM	**DISCUSSION**	**ACTION LOG**
1. Acknowledgement of Traditional Owners	The Deputy Chair acknowledged the Whadjuk people of the Noongar Nation. Respects were paid to Elders past, present and future for their knowledge and traditions.	
2. Welcome and apologies	The Chair welcomed attendees and noted apologies.	
3. Recognition of Lived Experience	The Chair recognised those with lived and living experience and acknowledged the emotional labour that comes with it.	
4. Reflection Item	The Chair presented the reflection item: **VIDEO –** What if the mental health system was designed by the people who use it?! **– Mary O'Hagan** Members discussed the following: • The video represented the proposed direction the mental health system should take, shifting away from primarily tertiary care and "big psychiatry" to a stronger focus on community support and holistic care, or "big community". • The language in psychiatry is exclusionary as it is difficult for a large number of people to understand and digest. • A shift from away from psychiatry may be difficult to implement due to resistance from within the current system.	**Note**: Nafiso Mohamed to provide reflection item for next meeting.

	• Mental Health Advisory Council (Council) members can support this shift by using a holistic, Aboriginal approach to mental health, where concepts that are good for Aboriginal people are good for everyone. • More community services are now available such as Hospital in the Home, indicating a shift in direction. Changes will still need to be accepted at a grassroots level and this could be a slow task. • Discussions within the mental health sector indicate a desire to create change, however there are no change management plans in place to ensure changes are implemented and create the desire for people to enact the changes. • Council to consider inviting a guest from the psychiatry sector to attend a future meeting to discuss what changes can be made and assist Council members in identifying areas of improvement.	**Action 204: Chair to advise on a representative from the Psychiatry sector for a presentation at a future meeting to discuss what improvements can be made to the current system.**
5. Conflicts of Interest	Richard Oades noted he is a Board Member of the Recovery College of WA, along with Kerry Hawkins.	**Note:** Secretariat to update the Conflict of Interest Register.
6. Acceptance of previous meeting minutes	Council members endorsed the 14 April 2022 meeting minutes.	
7. Action Log	**<u>Outstanding actions:</u>** • **Action 26**: Attendance of Mental Health Commission Elders in Residence, Uncle Charlie and Aunty Helen Kickett is still to be confirmed. • **Action 194**: The outcome of the Commissioner's discussions with the Pharmacy Guild will be carried forward. • **Action 179, 178, 149** – Invitations to be drafted	
8. Budget	Expenditure is under budget.	
9. Consumer and Carer Representatives from the MHEC and CMC	Amanda Waegeli, Consumer representative and Kerry Hawkins, Family and Carer representative on the Mental Health Executive Committee (MHEC) and the Community Mental Health, Alcohol and Other Drug Council (CMC) provided a lived experience update. Members discussed the following:	

	• Little change has occurred since the last discussion with a shift in focus required away from system concerns to focussing on individual's concerns. • The progress within indigenous systems was identified as a learning opportunity. • Encouragingly, there are more designated Lived Experience (LE) representative positions at higher levels. However, the creation of these roles has highlighted internal struggles with drafting job descriptions and the recruitment process. Identifying how to keep individuals in these roles will now need to be addressed. • It was noted the Mental Health Commission (MHC) has tight deadlines to complete tasks that require time, expertise, knowledge and experience. • The MHC wishes to effect change however, it has insufficient resources and requires more capacity building with further designated LE roles required within the MHC. • The MHC has an educative role, and the importance of this task will require the opportunity for more discussion to take place. • Amanda and Kerry noted proxies have been accepted for both of their LE roles within the MHC, providing networking opportunities for proxies and the opportunity for different viewpoints and perspectives within conversations. • It was suggested the MHC should review the organisational structure changes that arose from the Royal Commission in Victoria. The changes had strong ministerial backing with a whole of cabinet and government approach, which is essential to enact change. This review was ground-breaking and projects are being undertaken to address harm caused by the system. Changes are being implemented at a systemic level by reviewing the mechanisms through an LE lens. • There is only one designed LE position within the MHC. There is still fragmentation between the MHC, the Department of Health and Mental Health Units, as to who is responsible for drafting documentation. • A proposed change management structure was submitted to the MHEC and CMC over 12 months ago, outlining the proposed organisational structures to create a centre of excellence, however, there has been no progress on this to date. • The LE Workforce Framework is progressing however the system and organisational readiness work has not begun. There is an appetite within the MHC however it was felt this is driven by a health agenda rather than expertise and is reactive. • Workforce capacity building needs to be addressed to ensure a workforce is available to fill positions. It needs to be determined who will resource and support these individuals. The	

	positions must also be appropriately renumerated and there must be a formal structure in place to support peer workers. • Some discussion took place regarding training and mentoring of these LE individuals to ensure succession planning is identified as this is vital. Members had not considered this aspect and the discussion highlighted a gap and how the MHAC can provide support was questioned. • Members identified the language used can cause frustration and be difficult to understand. Language must be simple so the messages can be taken back to groups such as youths and Aboriginal communities and be understood. The Chair acknowledge the abundance of emotions – struggle, frustration and also determination and the sense of what is left with is that we have to journey together and find allies in the system as it is too much for any one person to do. Heartfelt thank you for continuing to speak truth to power and in a space that is difficult.	
BREAK		
10. Deputy Commissioner, Operations MHC	Lindsay Hale, Deputy Commissioner, Operations MHC was an apology. The presentation will be carried forward to a future meeting.	**Note: presentation to be rescheduled.**
11. Applying a LGBTQIA+ Lens to Mental Health	Council member Emily Wilding, who is also a Youth Development Officer and Local Government Councillor, presented "Applying a LGBTQIA+ Lens to Mental Health". The opportunity to highlight concerns within the LGBTQIA+ community was appreciated. MHC employees Madi Ross from the Engagement Team and Cath Colvin from System Development joined as observers for the presentation. Members discussed the following: • The inappropriate LGBTQIA+ narrative, leading up to the federal election was noted. • Intersex and transgender experiences are often absent in discussions and need to be included. • Insufficient data is available for LGBTQIA+ as it is often collected via surveys and self-reporting which are "opt in", therefore, data is not fully and accurately captured.	

	• Current statistics indicate 4% of the population is known to be intersex however, this is likely higher. Given the levels of shame and stigma, coupled with inaccurate data, true statistics can only be estimated. • An effort was made to include LGBTQIA+ data in the 2021 census however, the government did not include it. Comprehensive data will therefore not be available for another 5 years until the next census, and even then, it is not guaranteed. • Members noted the lack of statistics relating to LGBTQIA+ minorities such as Culturally and Linguistically Diverse (CaLD) and Aboriginal communities. • The prevalence of suicide within LGBTQIA+ was noted as significant. The statics are alarming and must urgently be addressed. • LGBTQIA+ people are 2.5 times more likely to have been diagnosed or treated for a mental health condition in the past 12 months and 73% of LGBTQIA+ people over 18 have been diagnosed with a mental health condition. These statistics indicate the current system is not working and must be reviewed. • Individuals identifying as intersex often carry trauma from their experiences of the medical system. This trauma may continue to follow them through future medical experiences. It is vital these intersex individuals have positive interactions with the medical system, given 60% over the age of 16 have considered suicide because of their medical system experiences. For changes to be effective and address systemic problems, change will need to be implemented across the entire community. • There are good services available for LGBTQIA+ individuals under the age of 25, including Headspace and Perth Children's Hospital Gender Diversity Services (PCH GDS). However, the current waitlist for PCH GDS is 12-months. The availability of this service must therefore be addressed. • Limited services are available for LGBTQIA+ individuals aged 26 and over. These individuals rely on General Practitioners and the use of private psychologists. These psychologists often do not have personal transgender experience and the holistic focus, inclusive of the individual's non-transgender specific issues is often missed. A database of transgender psychologists is not available, often resulting in sub-standard care being chosen over no care at all. Practitioners who do have experience in the LGBTQIA+ sector are often found by word of mouth resulting in long waiting periods. • Treatment of transgender people in a hospital setting is often clinical and acute care is considered terrifying by many LGBTQIA+ individuals, creating a barrier to accessing	

	services. This results in less suicide attempts and more suicide completions and needs to be urgently addressed. • It was noted Headspace does not have a formal transition program for individuals turning 25, transferring to adult psychology. The individual clinician will attempt to transition them to another service however, a lack of services and clinicians within the system means there is nowhere to transition individuals to. • LGBTQIA+ representations on committees and taskforces needs to be greater as one individual being the sole voice, places a huge responsibility on that individual. • Social context and the rhetoric of current federal candidates is concerning and raises the question, what will be on the policy agendas of those parties. • Current services available for LGBTQIA+ were outlined, identifying further community support services are required for families and carers and they will need to address future requirements. • The MHAC provides a wonderful space for these discussions to be heard however, the message needs to be heard often and wider to gain traction. • The MHC can support LGBTQIA+ within mental health by addressing discussions at a whole of government level. • Members discussed what active "allyship" means and how members can enact change within mental health by focusing on a commitment to human rights. • When creating policy, the MHC should seek LGBTQIA+ individuals for their expertise and ability to champion in the sector. • The MHC must understand the community they are supporting to ensure they are providing the most appropriate services. • Without data, genuine change will be difficult. The MHC will discuss with the System Wide Data Working Group (SWDWG) and advise what is currently captured and if the group can collect more specific LGBTQIA+ data. Members expressed their gratitude for Emily's heartfelt and insightful presentation.	**Action 205: The MHC to advise what data the SWDWG currently captures and whether LGBTQIA+ can be incorporated.**

12. Discussion on presentations and advice to the Commissioner	Key questions for presenters • Council members agreed that they would consider and provide targeted questions for presenters to ensure that presentations are targeted to information the Council is keen to hear about. To assist with this, the Secretariat will provide additional information on presenters where possible. • An invitation to a future Council meeting will be extended to Dr Robyn Williams to discuss Foetal Alcohol Spectrum Disorder, linking the discussion to Public Mental Health services for Infant, Children and Adolescents aged 0-18 years (ICA) and the Graylands Reconfiguration and Forensic Taskforce (GRAFT). • Recommendations from Emily's presentations will be drafted and distributed for discussion prior to submitting to the Commissioner.	**Action 206: Dr Robyn Williams to be invited to discuss Foetal Alcohol Spectrum Disorder.** **Action 207: Richard Oades to draft advice on consumer and carer representation / lived experience participation training.**
13. Other Business	• State budget released today will include $10m for GRAFT planning. A group will develop the forensic model of care, initiated by the Department of Health and the MHC' s influence has been vital in achieving this. • Meetings will begin with checking in with members to shift the focus from transactional to a relationship method of interaction. • The independent review of the *Health Services Act of 2014* was discussed. The review will look at the health system to ensure there is transparency in relation to the distribution of funds.	
14. Values Reflection	All Council members provided value reflections as follows: • The reflection item set the tone for the meeting's discussions. • There was more hope in this meeting with a positive focus on LE and LGBTQIA+. • The discussions highlighted how difficult conversations can be turned into something hopeful with a way forward. • All voices were articulated during the meeting.	
Meeting closed at 12:23pm		
NEXT MEETING	**Thursday, 9 June 2022.**	