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Session II: Health and Communities

Discussion and Questions

Julianne Schultz: Thank you. What an inspiring panel. Thank you very much. That observation about the failure to implement the recommendations of Royal Commissions goes to the heart of the many of the issues that we are discussing here today. It happens in area after area, and I guess its flip side, or its corollary, is that there are endless trials which get funded and then fall over and the lessons don't get applied. How do we move from the knowledge to the action which needs to make it real. I'm interested in each of your responses to that, but then we'll go to questions from the audience as well. Maree, do you want to pick up on that? What needs to be done? What might be done through your thinktank or some other means to see that action coming rather than it just being all the talk?

Maree Teesson: I think communities and connections are going to be critical to that. I was really interested also listening to Bernie say that only 5% of your budget comes from government. I'm really interested in how we can mobilise other forces. In Australia we do not have those independent forces that then work towards to implementation. Sometimes it's funding, sometimes it's partnerships. It's the first time, for example, the BHP Foundation had lots of different challenges that has built those partnerships around mental health. I think that is really telling, Bernie, that so little of your funding comes from government, but it might also be the enabler for us to work to create the change that we need.

Elizabeth Elliott: Well, I think to get research into practice at the community level really involves co-design. It involves people to say at the outset what the important outcomes are. What we try to do is action research so that we are getting outcomes along the way. We're not just collecting data — it's a real partnership with regard to the hospital system and the implementation of findings from, say, randomised control trials. We need a real shift in the attitudes of the hospitals and the health systems to really allowing research to be embedded in the system. I know the Academy of Health and Medical Science has done a big piece of work on that. Of course, to get any research into practice, you need to have the clinicians on board, the people who are going to use it and really get their opinion and get their ownership. Otherwise, no clinical guidelines are ever going to be implemented.

Sally Redman: Sorry, it's not my strong point. Perhaps one that surprised you. Did I say this? I think we have to be in it for the long haul and I think that that requires an honest conversation. We're talking about really complex and endemic sort of problems, things that can't easily or quickly be fixed. I think we need to be clear about that and to select the most important actions that need to be done about the 9,000 recommendations. That's really challenging to get your head around. I think we need to start asking what the most important thing to do is. I've been really impressed with discussions recently about systems thinking and how we can best apply that, because

it recognises the complex intertwining of many of these factors. Then it starts to let you think about where the critical points for change are. What would be the most important thing? I think that's what Bernie was talking about, actually. I think that we could do well as a community to have some dialogue around that.

Julianne Schultz: Bernie, your insights? I think one of the big things of yours was breaking down those silos, wasn't it? That was really crucial.

Bernie Shakeshaft: We heard Alison talk about it. We're pretty good at defining these things. You've got 9,000 recommendations of which we can't put one in place? I think we get stuck in the big complex, "Can't do it, it's just too hard." Sit in the corner and have a cry, "Uh, we don't do it like that." This isn't a question of why can't you, how can't you, it's a question of *how can you*? When I look at the eight other communities we're in, you want to talk about a complex problem? Try and replicate what we did. Want to talk about a complex problem? Ask the six universities when they first bounced into Armidale and went, "Hey, I'll tell you what we're going to do. We're going to write this paper; we want to get some runs on the board. We're just going to define what it is BackTrack does, should take us a month."

Six academics, professors, all the smart guys: 12 months later each tearing each other apart, going: "What do you mean? It's just the kids that are 12 to 24." I go, "Yes, but if there's a kid that comes in at 11, we'll sort that out." We're constantly going, *how can we*? Not, how can't we? I think when you start doing that, one of my favourite sayings in the world, "After action comes clarity." Jump off the damn cliff. I scare the be-Jesus out of people going, "Oh, no, here he goes again. What new crazy idea?" But if you don't just jump sometimes and do stuff, then you're going to sit around defining the damn problem, worrying about how you can't do it. We've got 9,000 recommendations to implement. Which one are we going to implement? Tell you what, implement one. Just start with one damn step. That's my opinion.

Renae Ryan: Hi, I'm Renae Ryan from the University of Sydney. It was an amazing session. Thank you to you all. My questions for you, Bernie, you talked a lot about boys and young men: are girls involved in the program and do they have different issues? How do you deal with that? Or is it specifically for boys, the program?

Bernie Shakeshaft: I spent a lot of years in Central Australia, Tennant Creek, Warumungu. I saw what beautiful things were going on in Central Australia with the men and how they started taking care of the kids. I know there's lots of dysfunction and tough stuff, but when you see the beauty of it, when you go to Fitzroy and go, "Man, when you look for the gold, you don't have to look very hard to see it." When I came back to New South Wales, it was kind of designed on that. I spent years and years in remote communities and knocking around with the countrymen and deepest of respect. They taught me stuff that I went, "You know what, how simple is this? How simple is this? Those people deal with grief and loss better than anyone in the damn world." When you start to feel some of that stuff, you go, "Boy, that's what it is."

When I came back and we started, it was all very manly, but that was the drive, and the passion was to do something with these kids. At the time it was all about these young fellows running amuck, what do you do? Felt like a good swim lane for us. It was mostly blokes that were down there volunteering when we were starting. We really designed it and went on just specifically for boys. We've had a couple of goes with the girls. We have definitely had girls through, some of the girls work in the BackTrack work side of it, it's always around people: when you get the right people. I don't want to be running girls' program as a bloke, but when we've had really good female, strong female staff that go, "You know what, we got to do this." Then I go, "Happy to get out of the way. I'll find the funding, you do it." We've had different areas of it. You asked me does it get hard? Holy smokes. I don't know if it's the same in Sydney, man, but when you put the boys and the girls together, something weird happens. It all changes. It gets very tricky. Will we go there again at some stage? Sure. I'd like to see it on a different side though, because and it drives me mental.

John Myburgh: Thank you. I'm John Myburgh. I'm a Professor of Intensive Care Medicine in Sydney and I run a research institute to do large-scale clinical trials, particularly in intensive care. This has been a fantastic session and it resonates across the whole spectrum of healthcare. A couple of things I wanted us to highlight, ask a question: Was the access to funding for national priorities? Because the current funding model, to use Bernie's phrase, is broken. I could be stronger than that. We are living in a bottom-up competitive-funding model where the attrition rate of researchers and questions just gets lost every single year. I sit on research panels, and I weep when I see the projects that get cancelled and people lost in translation. One of the successes of the pandemic came out of the UK, where the national portfolio of research design targeted areas for the community to address and got the researchers to tender for those jobs. It's a reverse model.

Surely it is time in this country that we did the same thing. We've now got community engagement, we've got Indigenous people engaging in questions, the mental health issue that you've raised, Maree, at the forefront. Shortest time now as part of all these academies: to get a nationally funded body to identify areas of research and key clinical questions based on the innumerable inquiries and put out one or two issues, as Bernie outlines, and get the institutes to tender for those jobs and then produce an output as soon as possible rather than the bottom-up approach. I think it's high time that we did this in this country.

Maree Teesson: Point incredibly well made, John. Because where will the innovation come from in this country if we keep losing the creativity, particularly in the research base? That's an incredibly important point. I just shared the Million Minds mission for the Medical Research Future Fund, which was $60 million over the next five years. It costs more to put the sign up out the front here. I 100% agree with you, but we have to start creating those models also within an Australian environment. What is the business case for putting those models up? It'll be very different here from the UK. The UK has a lot more philanthropy and a lot bigger tradition and a better way of funding their researchers within universities. They just laugh at our system. It's like a house of cards. It's all just falling over.

The MRFF (Medical Research Future Fund, for those people who are not living in medical research) is an amazing $900 million a year fund. That's what it's supposed to grow to, but it doesn't fund people, it funds projects. We just keep lumping projects on. I 100% agree we need new models and I'd really like us seeing, putting up, I'm literally working on one at the moment for a business case for these types of institutes that you're talking about, or a network of institutes, because we could. I'd really love to talk to you about that. I've got one right now on mental health but we need a network of them, not just one. That was my answer. I 100% agree, yes, let's do it. Any academies want to talk to us, let's get that happening.

Sally Redman: Just to add to it, I would say I 100% agree as well, but if we think about co-production work, then we really need to recognise the fact that it's resource-intensive. You need to have resources to be able to set up communication. Governance models takes longer. The value is as much in the relationship that you build. As long as we keep having three-yearly or five-yearly injections of funds, then we're never going to be able to work effectively with communities.

Julianne Schultz: Yes. I think that the point that several of you have made is it's about that capacity-building, it's about the leadership capacity-building as well. The part of the thing with the research model that we have at the moment is, as you say, it's very competitive: an enormous amount of effort goes into writing applications, but a very small percentage get funded. And so you're missing out on that capacity that you're building. As you said, if you follow the person through to build that capacity that they can then have that impact. That applies in academia, it applies in communities. If people get churned through and don't get that support, then you don't get the chance to grow, as you've done, Bernie, in your job.

Bernie Shakeshaft: Could I just add a comment to that? I'm just listening to what you say: I go, "I'm not afraid of copying things that work." In fact, happy to do a quick bit of plagiarism — if it works, why not pinch it and use it? If there is a better model, whether it's in the UK or wherever, why aren't we just copying some of that stuff? If we know what we've got is busted and we've got something across the fence that you go, "Oh yeah, that kind of works," why aren't we doing that with incarceration? Just trot over and have a look at Finland and Sweden and go, "Man, they're working out what to do with these big buildings now that they've closed them down because there's only two or three kids in a whole freaking nation that are locked up?" I go, "Why aren't we just trotting over there and having a little bit of a look at what they do?" Heaven's sakes. Our funding model from Canada, in 2014 went over there, when trotting around it was the Gillard government first helped us out, going, "Oh, you come over here with this model that we've looked at where we just go, 49% government funding, 51% private funding, let's get on and do the job together." I go, "Why don't we just copy some of that stuff?" Seems to work.

Tony Cunningham: Tony Cunningham. I just want to comment on just what was raised here with the UK. Israel is another example of a country that moved really quickly in COVID. We did some good things, there's no doubt about it, but Israel moved incredibly quickly and was able to

link its best academic institutions from the Weizmann through to government in order to get their advice to the politicians as quickly as possible, with a COVID czar and implementation. That moved really fast. I was lucky enough to be one of a group of 19 people in a mission to Israel recently, which included two of our State Chief Health Officers. I think this concept of leanness between academia and government and a very short number of people linked in that chain is really important. They also put their findings out immediately. They weren't subject to politician control, or government control, so that the community could actually see what the advice was and would hold the government to account. We can learn certainly from overseas.

Julianne Schultz: Thank you. Yes, being adaptive I think should be one of our strengths and it has been from time to time.

Jen: Thank you. I'm Jen from UTS, so I also run ActivateUTS, which is a student organisation not-for-profit that serves all the clubs and run all the programs. Listening to all the conversations, for the past two years as a student, what I see is there's increasing challenging mental health, obviously. This is the issue that I face and most of my friends face. I did some stakeholder communication and I figured out that we didn't have a Mental Health First Aid program. So we started a Mental Health First Aid program. It's like a CPR but it's on mental health. But if you consider CPR, the statistic I learned is 99% of people learn CPR but never use it in their life. Which is a good thing.

But for mental health, even in my few years of experience, you encounter a lot of emotion, run high-stakes conversation with a lot of people, especially in the student community. In the past few years, student reaching out to student, each other's peer-to-peer connection, where you have challenges, but I have nothing to say to them. I don't know what to say when they ask me, I find this challenging in life. All I can say to them is, "Things will get better." But back in the days when looking at the COVID number of all things it's not getting better. Then we started this program. I was wondering: I know the conversation here is very high level, but through your research and everything you've done, is there something that I can implement? This is Tuesday so I can take it back and implement this on Friday. That doesn't cost much money, but it's effective and useful to students, as useful as, let's say, a mental health first aid training for students. Is something that we can do? Thank you.

Maree Teesson: Yes, and yes. Talk to me at lunch. 100%. Mental health first aid, it's great, but we are also a country of asking everyone, "Are you okay?" And then not having anything to follow up with it afterwards. I think that's great and I'd really like to talk to you about what you can do after you start that conversation. But it also does require a lot more investment than we put into this space. We heard that amazing story about teachers, our health workers. They are under incredible pressure at the moment, with the pandemic. I do think we have to do a reality check about it. It isn't just asking — it's about what we need to scaffold to help. How do we upscale all of these amazing projects? Anyway, yes.

Bernie Shakeshaft: Could I just make one quick comment before lunch? My brother's also a university professor. We're always arguing about stuff. That's how we got the

research going. When I'm with the kids at the shed, I go, "You got any questions?" And they go, "Yoh, where you been, man?" I get that. When my brother says, "Can I ask you a question?" I go, "Right, you've got 25 minutes and I better understand what you're talking about."

Maree Teesson: And I gave your brother his first academic job.

Julianne Schultz: Well, that's one of many lunchtime conversations. I would like to ask you to join me in thanking our panels for sharing their insights and experiences and pointing to some ways of improving this in future.