Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF PROFESSOR DAVID LEON COPOLOV AO

I, David Leon Copolov, Professor of Psychiatry, Monash University and Pro-Vice-Chancellor, Major Campuses and Student Engagement, of Monash University, Wellington Road, Clayton, Victoria 3800, say as follows:

1 I make this statement in my private professional capacity as a psychiatrist, academic and former researcher, the long-standing Executive Director of the Mental Health Research Institute of Victoria (from 1985-2004) and my previous governance experience as a Director of the Board of the Royal Women's Hospital (my term having ended on 30 June 2020) and on the Board of the Peter MacCallum Cancer Centre, with six years (2007-2013) as Deputy Chairman of that Board and five years (2005-2010) as Chair of the Research Committee of that Board. My experience, since 2009, in Senior Management at Monash University, Australia's largest university, has also guided my views and recommendations about 'big system' reform in the area of mental health. My opinions are not to be interpreted as being provided on behalf of Monash University, the University of Melbourne or any other institution or organisation that I am or have been associated with.

2 As detailed below, I do not have experience on the frontline of the public mental health system. However, I have had extensive peer contact with colleagues in the public mental health system, and am an ardent (but unappointed) advocate for those who are served by and who work in that system. I am also an aggregator of information from people associated with and documentary sources relating to the Victorian public mental health sector.

3 My evidence is either based on my own knowledge, or where I make statements on the basis of information provided by others, I believe such information to be true.

Background

Qualifications

4 My primary degree is a Bachelor of Medicine and Bachelor of Surgery, which I received in 1974 at the University of Melbourne.

5 I completed my psychiatric training at Prince Henry's Hospital, where there was a strong emphasis on psychotherapy and consultation-liaison psychiatry.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

6 I also hold the following postgraduate qualifications and memberships:

(a) Diploma of Psychological Medicine, University of Melbourne, 1979;

(b) Membership of the Royal Australian & New Zealand College of Psychiatrists, 1980;

(c) Fellowship of the Royal Australian & New Zealand College of Psychiatrists, 1982;

(d) Fellowship of the Royal Australasian College of Physicians, 1983;

(e) Doctor of Philosophy (PhD), Monash University, 1983. My PhD thesis topic was Aspects of the Measurement and Physiology of Immuno-reactive Beta Endorphin; and

(f) Master of Psychological Medicine, Monash University, 1986.

7 In 2011, I was awarded a Medal of the Order of Australia. In 2016, I was made an Officer in the General Division of the Order of Australia (AO) "for distinguished service to tertiary education administration, to medicine in the field of psychiatry, to mental health research, and to the community."

Roles and responsibilities

Current university roles

8 I am Pro Vice-Chancellor, Major Campuses and Student Engagement at Monash University in Clayton, Victoria. My roles include having strategic oversight of:

(a) the Clayton, Caulfield and Peninsula Campuses in relation to the manner in which they provide the best possible experience for our students (approximately 76,000 students), with a particular focus on working with the Student Presidents of the University's undergraduate and postgraduate organisations, on fostering co-curricular engagements and on directing the strategic development of the Peninsula Campus as it entered a new growth and consolidation phase in its history;

(b) the development and dissemination of the University's Mental Health Policy and Strategy as Chair of the Monash University Standing Committee on Mental Health; and

(c) the University's central leadership programs, in particular the Vice Chancellor's Ancora Imparo Student Leadership program (as Director).

9 I am also Professor of Psychiatry, Monash University and Professorial Fellow, Department of Psychiatry at the University of Melbourne. In these joint roles, I am engaged in:

(a) contributing to public mental health policy, including advocacy for enhanced services in the public mental health sector for patients with serious and enduring mental illnesses and also advocacy for and contributing to the understanding of the mental health aspects of Voluntary Assisted Dying;

(b) ongoing involvement in research publications, particularly in the fields of auditory hallucinations, public mental health policy and psychopharmacology;

(c) building collaboration and continuous engagement between Monash University and the University of Melbourne;

(d) mentoring psychiatric researchers; and

(e) contributing to the knowledge base regarding COVID-19, as a co-author of two Rapid Research Information Forum (**RRIF**) reports from the Office of the Chief Scientist of Australia – one on the most promising COVID-19 therapeutics[1] and the other on the most promising vaccines for COVID-19.[2,3]

Current leadership and governance roles

10 I currently hold the following appointments:

(a) Governor and Professorial Fellow for The Florey Institute for Neuroscience and Mental Health, since 2013; and

(b) a Trustee for the Finkel Philanthropic Foundation, since 2002.

11 In addition, I still practise as a consultant psychiatrist with a small private practice.

Prior roles

12 Between 2014 and 30 June 2020, I was a Director of the Board of the Royal Women's Hospital (**RWH**). The RWH Board's role is to have strategic oversight of the hospital's activities, including in the areas of risk management, health service monitoring. Its

[1] See letter dated 17 May 2020 available at <https://www.chiefscientist.gov.au/sites/default/files/2020-05/RRIF%20Q009%20Promising%20COVID-19%20Treatments%2017%20May%202020.pdf> [accessed 22 June 2020].
[2] See letter dated 11 May 2020 available at <https://www.chiefscientist.gov.au/sites/default/files/2020-05/rrif-covid19-promising-vaccines.pdf> [accessed 22 June 2020].
[3] For further information about the RRIF, see Australia's Chief Scientist, 'Rapid Research Information Forum (RRIF)' <https://www.chiefscientist.gov.au/RRIF> [accessed 22 June 2020]. The opinions I express in this statement are not made in my role as a RRIF contributing author, and various assertions and predictions of mine extend beyond the content of the RRIF reports.

governance scope reflects guidance from the Victorian Department of Health and Human Services (**DHHS**), in that it includes but is not limited to:

(a) "developing the organisation's vision, purpose, core values, strategic direction and objectives

(b) evaluating executive management's recommendations on important strategic and operational matters

(c) ensuring that the service delivers safe, quality healthcare to all consumers, minimising risk and meeting, exceeding and continuously improving the required clinical performance standards

(d) scrutinising key financial and non-financial risks to which the health service is exposed, and ensuring the implementation of an effective clinical performance, risk management, compliance and internal control framework

(e) ensuring the adequacy of internal regulatory and policy compliance systems

(f) adopting appropriate ethical standards, codes of conduct and appropriate behaviours, and ensuring that these are adhered to, including by directors themselves

(g) communicating and reporting to DHHS, the Minister and other key stakeholders in a transparent and insightful manner

(h) overseeing CEO performance management and management succession plans

(i) [overseeing] board succession and establishing / reviewing the board processes for continuous improvement and effective governance."[4]

13 Between 2015 and 30 June 2020, I was also the Chair of the Research Committee of the RWH. The committee is involved in providing strategic oversight of the hospital's research programs, on behalf of the Board.

14 In addition to the roles described above, my other relevant prior appointments include:

(a) Director of the Board of the Australian Nuclear Science and Technology Organisation (ANSTO) from 2008 to 2016; and

(b) Director of the Bio21 Australia Cluster from 2008 to 2013, which became Biomedical Research Victoria (BioMedVic).

[4] Department of Health and Human Services, 'The Directors' Toolkit: A resource for Victorian health service boards', available for download from Victoria State Government, 'Directors' Toolkit', <https://www2.health.vic.gov.au/hospitals-and-health-services/boards-and-governance/education-resources-for-boards/directors-toolkit> [accessed 4 July 2020] at p. 18.

15 I have also held several advisory appointments to the Federal and State Governments, including 12 years as a member of the Victorian Ministerial Advisory Committee on Mental Health and eight years as the psychiatric expert on the Australian Drug Evaluation Committee.

16 Attached to this statement and marked 'DC-1' is a copy of my Curriculum Vitae, which provides further details of positions I have held since I began my professional career in 1975, and my roles and responsibilities in those positions.

Research contributions

17 During my active research career, I was a Chief Investigator or Co-investigator on competitive grants – including ten National Health and Medical Research Council grants – which received more than $26 million in grant funding.

18 I have published more than 240 peer-reviewed papers, and more than 21 chapters, books or monographs. My publications are detailed in my Curriculum Vitae (DC-1).

The Adult Psychiatry Imperative

19 I am one of the two leaders of the Adult Psychiatry Imperative (**TAPI**), with the other leader being Professor Tarun Bastiampillai, from Flinders University. TAPI is a consortium of individual psychiatrists. The consortium has made a submission to the Royal Commission, titled 'Achieving parity of care' (**TAPI Submission**).[5] When I express an opinion in this statement based on my role at TAPI, I identify that to be the case. The consortium comprises 38 Australian psychiatrists (mainly academics and directors of clinical services) and a panel of 13 international mental health experts. One of our main goals in preparing the TAPI Submission was to ensure that we were presenting recommendations that are based on data and published works, to the extent that is possible.

20 There is an extensive set of information in the TAPI Submission that covers areas that were not the focus of attention of the Royal Commission's Interim Report, some of which this Witness Statement addresses in a supplementary manner. The extent to which I address and focus on issues in this witness statement is not necessarily proportionate to the degree to which I have strongly held views and wish to make recommendations about the Victorian Mental Health System. Many issues about which I believe are in the greatest need of attention, have been extensively detailed in the TAPI Submission and I do not wish to duplicate that material.

[5] A copy of the TAPI Submission is available online at <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/4815/6858/2736/The_Adult_Psychiatry_Imperative_update.pdf> [accessed 8 June 2020].

21 I am also a co-leader of the Consortium of Australian Psychiatrists and Psychologists, which has an overlap of members with TAPI and has made two submissions to the Productivity Commission's Inquiry into Mental Health.[6]

Model for a future mental health system

Impacts of COVID-19 on mental health and mental health services

22 The consequences of COVID-19 for mental health, and for mental health services, have been and continue to be very significant. A number of surveys which seek to measure the mental health and wellbeing impacts of COVID-19 have been conducted in Australia and internationally during the pandemic. I describe a number of the Australian and international surveys below, noting that this is a rapidly evolving situation, that all are potentially distorted by sampling bias, and that some of these reports are pre-acceptance preprints which discuss unpublished data.[7] In addition, the prevalence of assessed or self-assessed anxiety, depression and loneliness varies considerably from report to report, which is a function of survey methodology and assessment instruments used. On the whole these studies have shown, unsurprisingly, that there is a significantly increased level of anxiety and depression in communities around the world as a result of the COVID-19 pandemic.

Australian data

23 Described below are a number of surveys which seek to assess the mental health and wellbeing impacts of COVID-19 on Australians:

(a) In the largest peer-reviewed paper of Australian online survey data that I could find,[8] in a sample of 13,829 respondents from all Australian states and territories, 27.6% of respondents had scores indicative of clinical significant depression[9] (compared to one study showing 3.7% with such scores in the Australian community pre-COVID-19) and 24.5% had anxiety scores suggestive of clinical symptoms of anxiety[10] (in comparison to international studies showing 2-17% of

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[6] Submission 260 (before the release of the draft report), available at <https://www.pc.gov.au/__data/assets/pdf_file/0003/240735/sub260-mental-health.pdf> [accessed 8 June 2020]; and submission 882 (in response to the draft report), available at <https://www.pc.gov.au/__data/assets/pdf_file/0015/251115/sub882-mental-health.pdf> [accessed 8 June 2020].

[7] Pre-print articles have not been peer-reviewed and report research that has yet to be evaluated. For clarity, I have used ** in this section to denote where an article is a pre-print and was yet to be accepted at the time I accessed it.

[8] Jane RW Fisher et al, 'Mental health of people in Australia in the first month of COVID 19 restrictions: a national survey', Medical Journal of Australia, (**pre-print, published online 10 June 2020), <https://www.mja.com.au/journal/2020/mental-health-people-australia-first-month-covid-19-restrictions-national-survey> [accessed 30 June 2020].

[9] Measured by scores of 10 or greater on the Patient Health Questionnaire 9 (PHQ-9).

[10] Measured by scores of 10 or greater on the Generalised Anxiety Disorder Scale 7 (GAD-7).

the population with similar levels of anxiety pre-COVID-19). The authors note that, contrary to their expectations, depression was more common than anxiety.

(b) Data from the Melbourne Institute, which has published weekly reports tracking the wellbeing of Australians during the COVID-19 pandemic, reported similar levels of anxiety and depression.[11] Weekly polling data of 1,200 Australians aged 18 years and over between April and June 2020 show that the proportion of people who reported feeling depressed or anxious most of the time ranged between 15-20%, and a further 22-28% reporting feeling that way some of time.[12]

(c) An online survey was administered to 5,070 adults in Australia at the height of the COVID-19 virus outbreak (27 March – 22 April 2020). The results showed that there was evidence of worsening mental health among respondents, who reported uncertainty about the future, loneliness and financial concerns: 62% reported elevated depression, 50% reported elevated anxiety and 64% reported elevated stress. Those who self-reported a history of mental health diagnosis had significantly higher levels of distress.[13]

(d) The ABC has published a number of vox pop surveys which focus on how Australians feel about the COVID-19 pandemic.

(i) The first wave of the survey was conducted between 18 and 22 April 2020 with 2,297 respondents.[14] When asked about mental health, 3% of people said that their "mental health in general" (which I understand to mean their pre-COVID-19 mental health) was poor. This figure more than doubled to 7% of people reporting poor mental health "at present". Reports of pre-pandemic to past week despair increased from 2% to 9%, loneliness increased from 6% to 20%, anxiety increased from 13% to 22%, stress increased from 14% to 29% and happiness decreased from 64% to 50%.

(ii) Importantly, respondents strongly approved of the way that the Prime Minister and Premiers were handling COVID-19, and supported tight restrictions (presumably on the basis that they were keeping infection rates very low). This, coupled with the important improvement in feelings solidarity from 30 to 40%, suggests to me that a factor that I would

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[11] The University of Melbourne, Melbourne Institute, 'Impact of COVID-19', <https://melbourneinstitute.unimelb.edu.au/publications/research-insights/covid-19> [Accessed 27 June 2020].

[12] The University of Melbourne, Melbourne Institute, 'Taking the Pulse of the Nation Tracker', <https://melbourneinstitute.unimelb.edu.au/data/covid-19-tracker> [accessed 27 June 2020].

[13] Jill M. Newby et al, 'Acute mental health responses during the 5 COVID-19 pandemic in Australia', (**pre-print, published online 12 May 2020), <https://www.medrxiv.org/content/10.1101/2020.05.06.20093773v1> [accessed 27 June 2020].

[14] Matt Liddy, Catherine Hanrahan and Joshua Byrd, 'How Australians feel about the coronavirus crisis and Scott Morrison's response', *ABC News*, 28 April 2020, <https://www.abc.net.au/news/2020-04-28/coronavirus-data-feelings-opinions-covid-survey-numbers/12188608> [accessed 27 June 2020].

consider "national self-esteem" may be an ameliorating protective factor which has kept the levels of mental distress lower than they could have otherwise been during the pandemic. As Alex Haslam and others have described it, the psychology of COVID-19 is the psychology of "us-ness".[15] The sense of solidarity in Australia can be contrasted with the comparative lack of such solidarity (if news reports are accurate) in the US and the UK.

(iii) A subsequent survey reported in late May 2020[16] showed that the proportion of Australians who were 'very concerned' about the pandemic had increased (to 36% from less than 30% in each of the four preceding weeks), despite a loosening of restrictions. 16% of people were 'extremely concerned' about a friend or family member contracting COVID-19, an increase of 3-4% over the previous four weeks.

24 Data from 1,000 Australian general practices show "up to 20%" increases in the prescription of anti-anxiety, and antidepressant medication in the wake of COVID-19.[17] These data offer a supplementary and confirmatory approach to assessing the level of anxiety and depression in the community during the pandemic.

25 There has also been research in Australia focused on the psychological impacts of losing employment during the COVID-19 pandemic. For example, one pre-print study of 551 participants states: "There was a high prevalence of psychological distress in people losing work during the coronavirus pandemic. Age, gender, job loss and social interactions were strongly associated with distress. Interventions that promote social interaction may help to reduce distress during among people losing work during the

[15] See for example Jolanda Jetten et al, 'Together Apart: The psychology of COVID-19', <https://www.socialsciencespace.com/wp-content/uploads/Together-Apart-Uncorrected-proof.pdf> [accessed 27 June 2020].

[16] Casey Briggs, 'Australians are more worried than ever about the coronavirus pandemic, survey reveals', *ABC News,* 27 May 2020, <https://www.abc.net.au/news/2020-05-27/australians-more-worried-about-coronavirus-than-ever-survey/12290918> [accessed 27 June 2020].

[17] Antidepressants are often used for anxiety as well as depression. See Alanah Frost, 'Prescriptions surge as anxiety mounts', *Herald Sun*, 30 June 2020, <https://readnow.isentia.com/Temp/129109-605510/1295210855.pdf> [accessed 2 July 2020]; Heather Saxena, 'Coronavirus: GP antidepressant scripts rise by 20%', *Australian Doctor News*, 26 June 2020, <https://www.ausdoc.com.au/news/coronavirus-gp-antidepressant-scripts-rise-20> [accessed 2 July 2020].

COVID-19 pandemic."[18] In addition, media reports indicate a differentially significant impact of COVID-19-related unemployment on women[19] and young people.[20]

26 While the surveys described above provide relevant insights into the psychological and psychosocial impacts of COVID-19 in Australia, a rapid review article highlights the paucity of information available regarding:

(a) the impact on and management of people with psychotic illnesses during pandemics; and

(b) how one might predict the impact of COVID-19 on people with these illnesses and manage them optimally.

This article also describes the difficulty that some people with psychotic illnesses may have in sticking to required public health restrictions, including social distancing, and how that might be best addressed, having regard to the practical and ethical considerations involved.[21]

UK data

27 Surveys conducted in the UK during the COVID-19 pandemic indicate that the levels of anxiety in people with experience of mental illness as well as the general community are very significant. [22] The surveys also showed that:

(a) isolation is a dominant concern for many people. Surveys revealed widespread concern about the impact of self-isolation, social distancing and quarantine on mental health.[23] Isolation of elderly people in aged care facilities (where any

[18] Alex Collie et al, 'Psychological Distress Among People Losing Work During the COVID-19 Pandemic in Australia', (**pre-print published online 12 May 2020). <https://www.medrxiv.org/content/10.1101/2020.05.06.20093773v1.full.pdf> [accessed 27 June 2020]).

[19] See for example Matt Wade, 'Scott Morrison is betting on a shovel-led recovery but the jobs bonanza is elsewhere', *The Age*, 7 June 2020, <https://www.theage.com.au/business/the-economy/scott-morrison-is-betting-on-a-shovel-led-recovery-but-the-jobs-bonanza-is-elsewhere-20200605-p54zz9.html> [accessed 27 June 2020], which states: "The data shows the downturn has hit women especially hard so far. Women's employment plunged by 325,000 in April compared with a fall of 270,000 for men. Paid hours worked by women crashed by 11.5 per cent in the month while the decline for men was a less severe 7.5 per cent.".

[20] See for example Jemimah Clegg, 'COVID-19 pandemic: How will youth unemployment affect Gen Z's ability to buy a home?', *Domain,* 26 May 2020, <https://www.domain.com.au/news/covid-19-pandemic-how-will-youth-unemployment-affect-gen-zs-ability-to-buy-a-home-957694/> [accessed 27 June 2020], which states: "Young people have been disproportionately affected by COVID-19 job losses – more than 200,000 people aged 15 to 24 became unemployed in April, accounting for 36 per cent of the job losses in that month, even though they only made up 15 per cent of the workforce in 2019".

[21] Ellie Brown et al, 'The potential impact of COVID-19 on psychosis: A rapid review of contemporary epidemic and pandemic research', *Schizophrenia Research*, 2020, (in press, available online 6 May 2020), <https://www.sciencedirect.com/science/article/pii/S0920996420302577> [accessed 27 June 2020].

[22] See discussion in Emily A Holmes et al, 'Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science', The Lancet Psychiatry. 7 (2020), 457-560. The surveys discussed are: The Academy of Medical Sciences. 2020, <http://www.acmedsci.ac.uk/COVIDmentalhealthsurveys> [accessed 14 May 2020]; Ipsos MORI, 'Covid-19 and mental wellbeing'. 2020, <https://www.ipsos.com/ipsos-mori/en-uk/Covid-19-and-mental-wellbeing> [accessed 14 May 2020].

[23] A recent review of pre-COVID-19 data on the psychological impact of quarantine showed that most reviewed studies reported negative psychological effects from quarantine: see Samantha Brooks et al, 'The

COVID-19 outbreaks run the risk of being extensive), and grandparents not seeing grandchildren, have been identified as particularly distressing effects of COVID-19;

(b) fear of exacerbation of mental illness and concern that people will become unwell as a result of the pandemic is common;

(c) many people with experience of mental illness or supporting people with mental illness are deeply concerned about accessing required mental health support during the pandemic;

(d) people are concerned for their own and others' health and loss of life; and

(e) many people fear that isolation from friends and family may negatively impact relationships.

The Australian surveys discussed above, and my own observations, indicate that Victorians are also experiencing these concerns, notwithstanding that the toll of COVID-19 pandemic has been, to date, much more severe in the UK and many other countries outside Australia.

Applying a model of disaster to the COVID-19 pandemic

28 A widely used and well regarded psychological model regarding phases of a disaster was developed by the Substance Abuse and Services Administration in the United States. Consideration of the model may be of value in order to prepare for future developments that might occur in the wake of COVID-19. The six phases of disaster in this model are:[24]

(a) "The **pre-disaster phase**", evidenced by feelings of fear, uncertainty and vulnerability.

(b) "The **impact phase**", which involves intense emotional responses that can include shock, gradually changing in emphasis to more concentration on self-preservation.

(c) "The **heroic phase**", in which there is a high level of activity together with strong feelings of altruism.

(d) "The **honeymoon phase**", which often features high levels of community bonding and high levels of optimism.

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psychological impact of quarantine and how to reduce it: rapid review of the evidence', *The Lancet*, 395.10227 (2020), 912-920, <https://doi.org/10.1016/S0140-6736(20)30460-8> [accessed 3 July 2020].

[24] See Substance Abuse and Mental Health Services Administration, 'Phases of Disaster' <https://www.samhsa.gov/dtac/recovering-disasters/phases-disaster> [accessed 2 June 2020]. Adapted from Zunin & Myers as cited in DeWolfe, D. J, 'Training manual for mental health and human service workers in major disasters' (2nd ed., HHS Publication No. ADM 90-538, 2000). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

(e) "The **disillusionment phase**", which is characterised by a realisation of the limits of support and feelings of abandonment.

(f) "The **reconstruction phase**" which is marked by communities beginning to recover and rebuild, while also continuing to grieve for losses, especially after catastrophic events.

29 It is of course, important to consider this model to be primarily of heuristic value in that there are gradations and intermixtures of responses throughout the overall mental health responses to catastrophic events. Australians had a number of weeks to prepare for the 'impact' of COVID-19, with awareness being heightened with various announcements by the Government highlighting the significance of the infection.[25] There were three and half weeks between the announcement by China of a "mysterious pneumonia" on 31 December 2019 and the first case in Australia (25 January 2020), and seven and a half weeks between the initial cases in our country and the cumulative total of 100 Australian cases.

30 Although it is very difficult to 'take the emotional pulse' of the population, it is my sense that the heroic and honeymoon phases were at their peak during the latter part of March 2020 and for much of April 2020. This was especially the case when it became apparent that the Commonwealth, states and territories were working together very strongly and effectively and that the public health containment measures were even more successful than many might have predicted.

31 At the time of providing this witness statement (early July 2020) there are suggestions of disillusionment in terms of 'fatigue' in relation to both physical distancing and other health-protecting restrictions. This has been manifest by some people ignoring very strong messages—and laws—by holding mass rallies[26] (whilst acknowledging the worthy cause for doing so) and creating a significantly enhanced risk of spreading the virus. This may have contributed to the recent and substantial increase in the number of new coronavirus cases in Victoria, which has increased up to 106 per day on 4 July 2020, with 12 postcodes in lockdown and more than 3,000 tenants in public housing towers going into

[25] Examples of these announcements include the blocking of arrivals from China on 1 February 2020 and the swift ramping up of containment and social distancing measures from 13 March 2020, as well as the announcement by the World Health Organization (**WHO**) that COVID-19 had pandemic potential on 21 January 2020 (but delayed notification by the WHO of this being a pandemic until 11 March 2020). See Helen Branswell and Andrew Joseph, 'WHO declares the coronavirus outbreak a pandemic', *Stat News,* 11 March 2020, <https://www.statnews.com/2020/03/11/who-declares-the-coronavirus-outbreak-a-pandemic/> [accessed 1 July 2020]; ABC News Digital Story Innovation Team, Inga Ting and Alex Palmer, 'One hundred days of the coronavirus crisis', *ABC News,* 4 May 2020, <https://www.abc.net.au/news/2020-05-04/charting-100-days-of-the-coronavirus-crisis-in-australia/12197884?nw=0> [accessed 1 July 2020]; Erin Schumaker, 'Timeline: How coronavirus got started – The outbreak spanning the globe began in December, in Wuhan, China', *ABC News,* 24 April 2020, <https://abcnews.go.com/Health/timeline-coronavirus-started/story?id=69435165> [accessed 1 July 2020].

[26] Victorian police fine Melbourne Black Lives Matter rally organisers, infected protester did not have COVIDSafe app', *ABC News*, 12 June 2020, <https://www.abc.net.au/news/2020-06-12/victoria-coronavirus-cases-protester-did-not-have-covidsafe-app/12347770> [accessed 4 July 2020].

"hard lockdown", leading to a significant increase in community concern, especially amongst the affected residents.[27]

32 Overall and across the world, we are in a phase that is best summed up by Dr Nathaniel Morris, who describes the pandemic as giving rise to a combination of "the gravity that pulls us together, the sense of duty to remain apart, the fear of infection, and the emptiness of the space between us."[28]

33 There is a definite sense of uncertainly about the future, given that: a vaccine may be many months, if not years, if not an eternity from being successfully deployed throughout the world; there is a risk of second and subsequent waves of infection, given the absence of herd immunity; and the Government cannot continue huge economic job saving programs of the magnitude initially introduced on an ongoing basis. Nevertheless, despite these uncertainties, it is my view that the level of community solidarity remains very high. As a local example of solidarity, nearly 90% of staff members at Monash University who voted, did so in favour of reducing elements of their pay and conditions in order to save 190 fellow staff members from being made involuntarily redundant.[29]

Government responses to the mental health and wellbeing impacts of COVID-19

34 Both the Commonwealth Government and the Victorian State Government have announced a range of measures, and invested many millions of dollars into programs to assist people with the psychological and psychosocial impacts of the COVID-19 pandemic. These programs include dedicated COVID-19 helplines and specific measures to provide additional support for children and for people facing domestic violence. In the face of COVID-19, there has also been a great deal of mental health work and peer support work in the community by way of telehealth.

35 I set out further details of the various government initiatives below. In my view, while these programs are important, many of the most important investments are not the direct investments in mental health programs, but rather the investments in containment of the virus and in economic measures.[30] The rate of increase in COVID-19 cases in Australia was doubling every three to four days during March 2020. If that rate had not peaked as it did on 29 March 2020,[31] we would have seen many hundreds, if not thousands of new

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[27] David Estcourt and Clay Lucas, 'Thousands of public housing tenants under hard lockdown as COVID-19 spreads', *The Age*, 4 July 2020, <https://www.theage.com.au/national/victoria/thousands-of-public-housing-tenants-under-hard-lockdown-as-covid-19-spreads-20200704-p5590s.html> [accessed 4 July 2020].
[28] Nathaniel P Morris, 'Staying Apart During a Pandemic'. *JAMA Internal Medicine*, (**published online ahead of print, 29 June 2020). doi:10.1001/jamainternmed.2020.2505.
[29] Monash University, 'Jobs Protection Framework – Staff ballot result for proposed variation' (1 July 2020) <https://www.monash.edu/news/articles/jobs-protection-framework-staff-ballot-result-for-proposed-variation> [accessed 2 July 2020].
[30] Investments in economic measures include maintaining, even if temporarily, job continuity by means of JobKeeper and providing financial support to vulnerable and especially affected individuals and households.
[31] See Inga Ting, Nathanael Scott and Michael Workman, 'Charting the COVID-19 spread in Australia, *ABC News*, 17 March 2020, (Updated 26 June 2020), <https://www.abc.net.au/news/2020-03-17/coronavirus-

cases each day since then. That magnitude of COVID-19 spread would not only have caused significant morbidity and mortality, but in my view, would also have caused much higher levels of stress and distress in the community than we are seeing now.[32]

36 In addition to vitally important new telehealth measures, the Commonwealth Government has invested more than $122 million in mental health initiatives that are in response to the COVID-19 pandemic. These include:[33]

(a) the establishment of a dedicated COVID-19 support line which is being provided by Beyond Blue;

(b) a digital mental health portal, Head to Health, to provide information and guidance about the maintenance of good mental health during the pandemic;

(c) a national COVID-19 mental health communications campaign being delivered by the National Mental Health Commission;

(d) help lines and apps to assist with the stresses being faced by health workers, women with perinatal anxiety and depression and the LGBTI community;

(e) reaching out to vulnerable groups, including older Australians, carers and people with mental illness, Aboriginal and Torres Strait Islanders and culturally and linguistically diverse communities;

(f) additional resources for youth mental health – to reduce waiting times in headspace centres;[34] and

(g) undertaking data modelling and research study the mental health impact of the pandemic into undertaking suicide prevention.

37 The Commonwealth funding to assist with the mental health of Australians since March 2020 sits alongside a much larger investment ($669 million) in telehealth consultations, many of which have enabled a continuity of mental health care, whilst facilitating ease of

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cases-data-reveals-how-covid-19-spreads-in-australia/12060704?nw=0> [accessed 27 June 2020]; Department of Health, 'Coronavirus disease (COVID-19) epidemiology reports, Australia, 2020' <https://www1.health.gov.au/internet/main/publishing.nsf/Content/novel_coronavirus_2019_ncov_weekly_epidemiology_reports_australia_2020.htm> [accessed 27 June 2020].

[32] In saying this, I note that I have not seen any comparison studies on the mental health effects of COVID-19 between countries with high rates of infection, with those who have significantly lower rates.

[33] The Department of Health published a fact sheet setting out the full range of measures to be funded in this package. The fact sheet is available at <https://www.health.gov.au/sites/default/files/documents/2020/03/covid-19-national-health-plan-supporting-the-mental-health-of-australians-through-the-coronavirus-pandemic.pdf> [accessed 3 June 2020].

[34] Katie Burgess, 'Coronavirus: Telehealth expansion to remain post-pandemic', *The Canberra Times*, 9 June 2020 <https://www.canberratimes.com.au/story/6786471/government-looking-to-keep-expanded-telehealth-hunt/#gsc.tab=0> [accessed 27 June 2020].

access by patients and clinicians and also simultaneously eliminating the risk of transmission of COVID-19.[35]

38 On 15 May 2020, the Commonwealth government released the National Mental Health and Wellbeing Pandemic Response Plan, which was developed under the co-leadership of the Victorian, New South Wales and Commonwealth governments.[36] The Plan is designed to guide the response of the Australian health care sector to the COVID-19 pandemic. The "purpose of the Plan is to identify the specific challenges to mental health and wellbeing associated with the COVID-19 pandemic and to outline the measures required to address them".[37]

39 The Plan sets out a number of priority areas for action that are categorised as either "immediate actions" or "ongoing key priority areas". The immediate actions are:

(a) **Data and modelling**: "immediate monitoring and modelling of the mental health impact of COVID-19".

(b) **Outreach**: adaptation of "models of care to changing sites of service delivery".

(c) **Connectivity**: improving service linkage and coordination.[38]

40 The Victorian Government also invested substantial amounts in COVID-19 related mental health initiatives. It allocated $54.9 million to a suite of initiatives which are helping, amongst other things, to:

(a) improve support for people with serious mental illnesses using teleconferencing and phone consultations, in order to prevent deterioration and presentation to emergency departments;

(b) augment online and phone counselling via Lifeline, Beyond Blue, Suicide Line Victoria and Kids Help Line;

(c) provide a state-wide expansion of the Hospital Outreach Post Suicidal Engagement (HOPE) program;

(d) accelerate the eOrygen Platform that provides peer support and online therapy for young people; and

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[35] Prime Minister of Australia, Media Release: '$1.1 billion to support more Mental Health, Medicare, and Domestic Violence Services', 29 March 2020, <https://www.pm.gov.au/media/11-billion-support-more-mental-health-medicare-and-domestic-violence-services-0> [accessed 1 July 2020]. See paragraph 78 below regarding the dramatic increase in telehealth services, including for mental health services, during the COVID-19 pandemic.

[36] Australian Government, 'National Mental Health and Wellbeing Pandemic Response Plan' May 2020, <https://www.mentalhealthcommission.gov.au/getmedia/1b7405ce-5d1a-44fc-b1e9-c00204614cb5/National-Mental-Health-and-Wellbeing-Pandemic-Response-Plan> [accessed 3 June 2020].

[37] Ibid. at p. 7.

[38] Ibid. at pp. 6-7. As to connectivity, see also the discussion from paragraph 68 below.

(e) provide additional funding for special groups, including Indigenous Victorians, people from the LGBTI community and those with eating disorders and victims of family violence.

41 The State government also announced it would provide $17.8 million to fund the first phase of the roll out of the 170 extra youth and adult acute mental health beds, which was a key recommendation of the Royal Commission's Interim Report (at page 11).

COVID-19 in psychiatric inpatient facilities

42 It is inevitable that when people live in close proximity to one another, whether it be in hospital wards, aged care facilities, rehabilitation centres or prisons, they are at heightened risk of rate of inflections such as COVID-19. There is a contrast between the interactional and group activities that are central to inpatient care in psychiatric units and the dynamics within medical and surgical inpatient wards; in the latter, the patient essentially lies or sits as an individual in their hospital bed, largely isolated from other patients – except in the case of shared wards.

43 There have been a number of reports of COVID-19 outbreaks within psychiatric wards, including in the United Kingdom, the United States[39] and South Korea.[40] In Victoria the only outbreak in a psychiatric facility that I am aware of was at the Albert Road Clinic. The first case was reported at that hospital in late March 2020. At least 15 cases have been linked to that outbreak.[41] There was widespread community concern that the public was not informed of the outbreak in a timely manner.[42] One possible corollary of any delays in reporting COVID-19 infections in psychiatric hospitals to the psychiatric community is that clinicians who work at multiple clinical settings might unknowingly spread the infection to staff and patients – in both the private and public sector – as well as to friends and loved ones. That said, given the pandemic response and communication systems now in place in both the DHHS and in the private psychiatric healthcare system, I consider the likelihood of a recurrence of the problem of delayed and inadequately coordinated communication is small.

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[39] CBS News, 'Psychiatric hospitals face potential coronavirus outbreaks amid unique challenges', 20 April 2020, <https://www.cbsnews.com/video/psychiatric-hospitals-face-potential-coronavirus-outbreaks-amid-unique-challenges/> [accessed 13 June 2020]; Ethan Geringer-Sameth, 'Coronavirus Death Toll at State Psychiatric Facilities Climbs Quickly', *Gotham Gazette*, 25 April 2020, <https://www.gothamgazette.com/state/9336-coronavirus-death-toll-at-state-psychiatric-facilities-climbs-quickly> [accessed 13 June 2020].

[40] Min Joo Kim, 'How a South Korean psychiatric ward became a 'medical disaster' when coronavirus hit', *The Washington Post*, 1 March 2020, <https://www.washingtonpost.com/world/asia_pacific/how-a-south-korean-psychiatric-ward-became-a-medical-disaster-when-coronavirus-hit/2020/02/29/fe8f6e40-5897-11ea-8efd-0f904bdd8057_story.html> [accessed 25 May 2020].

[41] Albert Road Clinic, 'COVID-19 update from Albert Road Clinic' 25 May 2020. <https://www.albertroadclinic.com.au/About-Us/Novel-Coronavirus> [accessed 13 June 2020].

[42] See for example Michael Fowler, 'Families and doctors blast 'lack of transparency' over COVID-19 outbreak', *The Age*, 26 April 2020. <https://www.theage.com.au/national/victoria/families-and-doctors-blast-lack-of-transparency-over-covid-19-outbreak-20200425-p54n77.html> [accessed 1 July 2020].

44 More recently, in late June 2020 a health care worker at the Melbourne Clinic (Victoria's largest private psychiatric facility) returned a positive COVID-19-test, with the result that nine patients who had the closest contact with that person were put into isolation and the Melbourne Clinic has halted all new admissions.[43]

45 The broad implication for the risk of spread of COVID-19 or similar infection in psychiatric wards includes the need for clear pandemic preparedness plans. Examples of such plans include those from the DHHS[44] and the Royal College of Psychiatrists (UK) in conjunction with the Royal College of Nursing.[45]

46 A further implication is that now there is global awareness of the risk of pandemics, in the future, we will be ideally placed to design facilities that can minimise the risk of spread of infection, in a manner that current facilities are less likely to be able to do. This extends to both acute and rehabilitation facilities and facilities, such as those that my TAPI colleagues and I propose with Specialist Mental Health Centres.

The importance of infection control guidelines and personal protective equipment

47 Staff in the Victorian public and private mental health systems are (justifiably) concerned about their own health. The fact that health workers are at comparatively high risk for developing COVID-19 infection – with estimates of the percentage of all infections that are contracted by them varying from 4% (China) to 9% (Italy) to 13.6% (Spain)[46] – and outbreaks like that at the Albert Road Clinic, exacerbate these concerns. To help address this concern, health workers themselves have to be confident that they are being provided with consistent, clearly communicated and evidence-based advice about infection control, as well as all the necessary resources and advice about, and access to, personal protective equipment.

48 As noted at paragraph 45 above, the DHHS has developed a very useful guide to infection control,[47] but from my understanding in talking to colleagues in the public mental health

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[43] The Melbourne Clinic, 'Temporary suspension of new admissions', <https://themelbourneclinic.com.au/internal-pages/temporary-suspension-new-admissions> [accessed 2 July 2020].

[44] Victoria State Government, Department of Health and Human Services, 'Personal Protective Equipment (PPE) for the provision of mental health care', 4 June 2020, <https://www.dhhs.vic.gov.au/sites/default/files/documents/202006/Personal%20Protective%20Equipment%20%28PPE%29%20for%20the%20provision%20of%20mental%20health%20care.pdf> [accessed 1 July 2020].

[45] Royal College of Psychiatrists in association with the Royal College of Nursing, 'COVID-19: Inpatient services', <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/community-and-inpatient-services/inpatient-services> [accessed 1 July 2020].

[46] International Council of Nurses, 'High proportion of healthcare workers with COVID-19 in Italy is a stark warning to the world: protecting nurses and their colleagues must be the number one priority', 20 March 2020, <https://www.icn.ch/news/high-proportion-healthcare-workers-covid-19-italy-stark-warning-world-protecting-nurses-and> [accessed 1 July 2020]; Centre for Evidence Based Medicine, 'COVID-19 How many Healthcare workers are infected?', 17 April 2020, <https://www.cebm.net/covid-19/covid-19-how-many-healthcare-workers-are-infected/> [accessed 1 July 2020].

[47] See footnote 44 above.

system, there was not – but needed to be – a consistent and clearly communicated set of guidelines for mental health workers, until relatively recently. Unless health workers are given appropriate guidelines and sufficient protection, it is very difficult for them to provide the care that is needed in the community. This is particularly important so that workers can deliver services to people who are too unwell to access services via technology, or who need to be seen in-person because they do not have access to clinical services by other means of technology. I discuss this cohort of people further below in the context of telehealth.

Impact on hospital presentations and admissions

49 Another phenomenon associated with COVID-19 is that, for the first time in many years, there were empty beds for mental health patients in some public hospital wards. The number of emergency department presentations dropped significantly during the early part of the COVID-19 pandemic, and some hospitals had excess staff. I understand there was a reduction in demand for beds in low dependency units but the demand for beds in high dependency units in the public sector was high throughout the COVID-19 peak and remains high. By June 2020, demand for low dependency beds was returning to 'normal'. I understand there was also a reduction in the demand for beds in private psychiatric hospitals, but by early June 2020, there had been a 'return to normal'. The commonly accepted view is that the reason for the reduced numbers is that people were avoiding going into hospital out of fear of contracting COVID-19.

50 We know that the processes that cause illness are not stopping simply because people are not going into hospital in the usual numbers. The difference is that unwell people are staying at home or perhaps seeking other forms of care outside of hospitals. Many practitioners are expecting that, after there has been a major abatement of concern about COVID-19, there will be a substantial rebound of patients with potentially increased morbidity coming into hospitals or needing other forms of medical care. That said, any major abatement of concern may continue to be intermittent because of increases in the number of infections, as has recently occurred in Victoria.

51 In a webinar on 3 June 2020, Dr Ruth Vine (Deputy Chief Medical Officer for Mental Health) and others provided an update for mental health care practitioners about the COVID-19 response.[48] With respect to the changes in the demand for mental health patient services, Dr Vine noted that demand in emergency departments for mental health presentations was reduced by 20-30% during the peak of COVID-19, but as at early June

[48] Department of Health, 'COVID-19 response update for mental health care practitioners – 3 June 2020', 3 June 2020, <https://www.health.gov.au/resources/webinars/covid-19-response-update-for-mental-health-care-practitioners-3-june-2020> [accessed 22 June 2020].

2020, demand is returning to normal (which I understand to mean that demand is returning towards being over-stretched).

52 Although my colleagues initially reported that psychiatric presentations to emergency department were fewer in number, they also reported that they were higher in acuity. That is, there appears to be a high rate of presentations by people with serious psychiatric symptoms. While there has been a reduction in pressure on psychiatric beds during COVID-19 to-date, that is not to say there will not be a significant rebound in the need for beds in future months and years. On one view, COVID-19 provides support for the argument that psychiatric wards should have a target maximum occupancy rate of around 85% (rather than 95% or 100%). This lower occupancy rate would provide scope to have separate areas within a psychiatric ward for people with COVID-19, if the virus, or other new infections, become endemic. COVID-19 has brought into focus major implications for new hospital design throughout the health sector.

Increased suicide rates and their link with the economic impacts of COVID-19

53 The COVID-19 pandemic not only gives rise to concern about an increase in the rate of serious psychiatric symptoms, but also to an increase in the rate of suicide.[49]

54 An important paper published in *The Lancet Psychiatry* summarises the factors that might lead to an increased rate of suicidal behaviour as a result of COVID-19, the restrictions that have been imposed and the hardships that they are causing.[50] The paper also discusses mitigating measures that should be put into place.[51]

55 Since 2009, the rate of suicide in Australia has been in the range of 10.5 (in 2011) to 12.9 (in 2015) suicides per 100,000 people.[52] The most recent Australian Bureau of Statistics (**ABS**) data indicate that the suicide rate for 2018 was 12.1 per 100,000 people, which

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[49] For a discussion of the possible impacts of COVID-19 on suicide prevention, beyond the economic consequences, see: David Gunnell et al, 'Suicide risk and prevention during the COVID-19 pandemic' *The Lancet Psychiatry*, 7 (2020), 468-471, <https://doi.org/10.1016/S2215-0366(20)30171-1> [accessed 3 July 2020].

[50] Ibid.

[51] Ibid. See in particular the figure on p. 469.

[52] Australian Bureau of Statistics, '3303.0 - Causes of Death, Australia, 2018, Intentional self-harm, key characteristics (Latest issue released on 25 September 2019)' <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2018~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3> [accessed 27 June 2020]. An earlier report by the ABS reported the 2015 suicide rate as 12.7 suicides per 100,00 people: <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3> [accessed 27 June 2020]. For historical suicide data, see Harrison, JE and Henley, G 'Suicide and Hospitalised Self-Harm in Australia: Trends and Analysis' *Australian Institute of Health and Welfare,* Injury research and statistics series 93, Cat. No. INJCAT169 (2014); Tarun Bastiampillai et al, 'Why Are Australia's Suicide Rates Returning to the Hundred-Year Average, Despite Suicide Prevention Initiatives? Reframing the Problem From the Perspective of Durkheim' *Australian and New Zealand Journal of Psychiatry*, 54.1(2020),12-14.

equated to 3,046 suicides across Australia that year.[53] In Victoria, the rate was somewhat lower, at 9.1 suicides per 100,000 people (593 suicides).[54]

56 Concern about an increase in suicides is linked with the economic consequences of COVID-19 which are, and will continue to be, substantial. In addition to the many job losses to-date, there is significant financial uncertainty and insecurity of future employment, with unemployment rates predicted to rise above 10%. If we look at historical data on the impact of a severe economic downturn on suicide rates, we see a concerning picture. During the Great Depression, suicide rates increased to almost 17 people per hundred thousand (although that peak was only for one year, and returned the next year towards the average for previous years).[55]

57 Our society today has many positive differences to the era of the Great Depression, including more social support and a rapid economic response including the $70 billion investment in the JobKeeper program. There has also been a very significant set of mental health measures that have been instituted by both the Commonwealth and State governments, with suicide prevention measures being prominent amongst them.[56]

58 In my view, these factors will help to powerfully buffer the potential increase in suicide rates during this period of economic uncertainty. However, if the suicide rate were to increase to anywhere near the 17 people per 100,000, the number of people suiciding in Victoria would increase by up to a few hundred people in a year, on top of what was an already substantial increase in Victoria.[57] For this reason, very close attention to this issue at all levels of government is essential.

59 Despite the increase in the number of calls to suicide and crisis helplines,[58] to my knowledge there is no current signal of increased suicides during the COVID-19

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[53] Australian Bureau of Statistics, '3303.0 - Causes of Death, Australia, 2018, Intentional self-harm, key characteristics (Latest issue released on 25 September 2019)' <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2018~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3> [accessed 27 June 2020].

[54] Ibid.

[55] Australian Bureau of Statistics, '3309.0 Suicides, Australia (1921-1998)' <https://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/B677BAE5E1AC97E5CA2568BD0012ECBC/$File/33090_1921%20to%201998.pdf> [accessed 27 June 2020]. Table 1 (p. 15) shows that the age-standardised suicide rate in 1930 was 16.8 suicides per 100,000 people and by 1943, this had dropped to 7.7 suicides per 100,000 people.

[56] The measures are described above, particularly at paragraph 36.

[57] Kristian Silva, 'Victorian Coroner warns of 'staggering' suicide rate as investigation launched into Whittlesea deaths', *ABC News*, 5 June 2020, <https://www.abc.net.au/news/2020-06-05/victorian-coroner-concerned-about-rising-suicide-rate/12324404> [accessed 27 June 2020].

[58] Hannah Wootton, 'Experts warn of spike in youth suicide as recession hits', *Australian Financial Review*, 12 June 2020, <https://www.afr.com/policy/health-and-education/experts-warn-of-spike-in-youth-suicide-as-recession-hits-20200612-p551x9> [accessed 27 June 2020]; Mark Saunokonoko, 'Lifeline calls at record high as Aussies struggle with horror 2020', *Nine News*, 10 June 2020 <https://www.9news.com.au/national/coronavirus-bushfires-mental-health-australians-calling-lifeline-in-record-numbers/50dc72f2-d23f-437b-84eb-f21e4bb460ef> [accessed 27 June 2020]. See also Sophie Scott and Elise Kinsella, 'Mental health and COVID-19 — how the coronavirus is affecting our way of life', ABC News, 18 April 2020, <https://www.abc.net.au/news/2020-04-18/mental-health-and-coronavirus-how-australia-is-reacting-covid19/12159750> [accessed 27 June 2020]; Shalaila Medhora, 'Calls to Lifeline jump

pandemic.[59] This could be because of the suicide prevention measures that have been and are being put into place.[60] It could also be a consequence of the traditional delay in reporting suicide data, which is one of the reasons why the Commonwealth Government has funded suicide prevention research and service improvement as part of its recently announced suite of mental health responses to COVID-19.[61]

60 Because unemployment is a significant risk factor in suicide, it is important to note that (at the time of preparing this statement) we are in a phase of government funding support to buffer to some extent against job losses. That said, according to the ABS, the unemployment rate increased to 6.4% in April 2020 and 7.1% in May 2020, in comparison to around 5% in April and May 2019.[62] In addition, market research company Roy Morgan estimates that in May 2020 more than 24% of Australians were unemployed or underemployed.[63] It is hoped that if all goes well in the next few months Australia will enjoy the fastest improvement in employment rates in its history, with more than 850,000 jobs being returned to or created in the economy.[64] But even with this improvement, employment is predicted to be 3.4% below March 2020 figures in September 2020.[65]

61 How our country manages unemployment will be an important factor that needs to be considered in relation to any modelling of poor mental health outcomes associated with COVID-19, including suicide. To emphasise this point, a 2009 study by Stuckler and colleagues of 26 European countries over 37 years demonstrated an association between unemployment and suicide rates, with every 1% increase in unemployment being

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20 per cent as coronavirus crisis takes hold', *TripleJ Hack*, 27 March 2020, <https://www.abc.net.au/triplej/programs/hack/calls-to-lifeline-go-up-due-to-coronavirus-covid-19/12096922> [accessed 27 June 2020].

[59] See for example the comments of Greg Hunt in Dana McCauley, ''These things can build up': $48m for COVID-19 mental health plan', *The Sydney Morning Herald,* 15 May 2020, <https://www.smh.com.au/politics/federal/these-things-can-build-up-48m-for-covid-19-mental-health-plan-20200515-p54te4.html> [accessed 27 June 2020], which states: "Mr Hunt said while no rise in suicide rates had been recorded in the initial four months of the pandemic, efforts were being made to "get ahead of the curve"."

[60] See footnote 30 above.

[61] Department of Health, Media Release: 'COVID-19: $48.1 Million for National Mental Health and Wellbeing Pandemic Response Plan', 16 May 2020 <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/covid-19-481-million-for-national-mental-health-and-wellbeing-pandemic-response-plan> [accessed 27 June 2020]. See also Stephanie Dalzell, 'National suicide register needed soon to manage increased risk from coronavirus', *ABC News,* 7 May 2020, https://www.abc.net.au/news/2020-05-07/national-suicide-register-needed-coronavirus-surge/12208668> [accessed 27 June 2020]; Dana McCauley, 'Real-time suicide data could be years away', *The Sydney Morning Herald,*, 1 June 2020, <https://www.smh.com.au/politics/federal/real-time-suicide-data-years-away-as-doctors-warn-of-mental-health-spike-20200529-p54xnl.html> [accessed 27 June 2020].

[62] Australian Bureau of Statistics, '6202.0 Labour Force, Australia, May 2020 (Latest issue released 18 June 2020)' https://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/6202.0?opendocument [accessed 27 June 2020].

[63] Roy Morgan, '2.09 million Australians unemployed in May, down 69,000 on April', 4 June 2020, <http://www.roymorgan.com/findings/8423-australian-unemployment-estimates-may-2020-202006040420> [accessed 27 June 2020].

[64] Jeff Borland, 'Why even the best case for jobs isn't good. We'll need more JobKeeper', *The Conversation*, 4 June 2020, <https://theconversation.com/why-even-the-best-case-for-jobs-isnt-good-well-need-more-jobkeeper-139648> [accessed 27 June 2020].

[65] Ibid.

correlated with a 0.79% increase in the rate of suicide at ages younger than 65.[66] There are also pre-COVID-19 data from the United States about the link between minimum income and suicide.[67] In addition, an investigation of the effect of the 2008 global economic crisis on suicide in 54 countries showed that there was an increase in suicide, mainly in men, following the crisis.[68] That study found that, in European countries, the increase was highest in men aged 15-24, whereas in the Americas, the greatest increase was seen in men aged 45-64. There was an apparent association between increased suicide rates and the level of unemployment, especially in countries which had experienced low pre-crisis levels of unemployment.

62 It is critically important for mental health perspectives to be introduced into key decision-making processes such as those relating to employment and other economic matters that influence mental health. At a state level, I would like to suggest that the Royal Commission might imminently request to the Victorian Government that a position equivalent to the Deputy Chief Medical Officer for Mental Health at the Commonwealth Government level, be established and for the incumbent to work closely with Professor Brett Sutton, the Victorian Chief Health Officer, on COVID-19-related mental health issues. Such a role should be served in the longer term by the Chief Mental Health Officer, a role that my TAPI colleagues and I have recommended should be established as part of the reform of the mental health system.[69]

<u>The potential for a differential suicide risk for different age groups, and difficulties with predicting change in suicide patterns as a result of COVID-19</u>

63 Any change in the pattern of suicide as a result of COVID-19 will be hard to predict, although Australian modelling is being developed in an attempt to do so.[70]

64 There is a plausible case for a differentially increased risk of COVID-19-related suicides in young people as a result of factors such as higher rates of unemployment relative to the rest of the population. However, the only publications I have identified relating to the 2003 SARS epidemic and suicide refer to an increase in suicides of elderly persons, especially elderly women, in Hong Kong.[71] The authors of that paper were careful not to overstate that there was a causal link between the epidemic and the increased rate of

[66] David Stuckler et al, 'The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis' *Lancet,* 374 (2009), 315–23.
[67] John A Kaufman et al, 'Effects of increased minimum wages by unemployment rate on suicide in the USA' *Journal of Epidemiology Community Health,* 74 (2020), 219-224.
[68] Shu-Sen Chang et al, 'Impact of 2008 global economic crisis on suicide: time trend study in 54 countries'. *BMJ,* 347 (2013), f5239, <https://doi.org/10.1136/bmj.f5239> [accessed on 6 July 2020].
[69] TAPI Submission, pp 82-83.
[70] See for example, Brain and Mind Centre. 'COVID-19 pandemic response: Every life matters: Preliminary evaluation' <https://www.sydney.edu.au/content/dam/corporate/documents/brain-and-mind-centre/mental-wealth/every-life-matters_final.pdf> [accessed 1 July 2020].
[71] Sau Man Sandra Chan et al, 'Elderly suicide and the 2003 SARS epidemic in Hong Kong', *International Journal of Geriatric Psychiatry*. 21.2 (2006), 113-118. Citations omitted.

suicide, but speculated that factors potentially contributing to an increased rate of suicide of the elderly include "physical health problems, marginalized social support ... depression, physical illness, social isolation, negative life events and frequent utilization of health care service."[72]

65 There has been no equivalent to COVID-19 in terms of its rate of spread and likely economic consequences, other than the influenza epidemic in 1918-19, which had a much higher mortality rate than COVID-19 currently has. Because of this, in order to gain insights into the possible effect of the infection on suicide rates, it might be best to look at a combination of studies that have investigated suicide in relation to previous epidemics, such as SARS,[73] as well as in relation to recessions[74] and natural disasters. As to the latter, a review of the effect of natural disasters on suicidal behaviours concluded that there appears to be a decrease in non-fatal suicide behaviours soon after the disaster period, with a delayed increase in suicidal behaviours reported in some studies. There was not, however, a clear relationship between the occurrence of disasters and a change in the rate of suicide.[75]

Other economic impacts

66 Another possible economic consequence of COVID-19 is that large numbers of people relinquish their private health insurance because of financial hardship. If this occurs, the pressures on the public mental health system (which has been under severe strain) are going to be made even worse.[76]

67 The pandemic may also have profound ramifications on the ability of governments to fund public mental health services. Attracting much greater philanthropic support for mental health care and research will become much more important if public funding is dramatically curtailed in the years ahead.[77]

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[72] Ibid at 117.
[73] See paragraph 64 above, but as noted there, the data on the link between suicide rates and SARS are limited.
[74] See paragraph 61 above.
[75] Kairi Kõlves and Diego De Leo, 'Natural disasters and suicidal behaviours: A systematic literature review', *Journal of Affective Disorders*, 146.1 (2013), 1-14.
[76] This possibility was raised by Associate Professor John Allan, President of the Royal Australian and New Zealand College of Psychiatrists, see 'President of psychiatrists' peak body says act now on mental health services', 27 April 2020, <https://www.ranzcp.org/news-policy/news/president-of-psychiatrists%E2%80%99-peak-body-says-act-now> [accessed 3 July 2020].
[77] For a discussion of the ability of 'Specialist Mental Health Centres' to be a focus of philanthropic activities in mental health, see pp. 13-15 of the submission of the Consortium of Psychiatrists and Psychologists (Submission 882) to the Productivity Commission Inquiry, 'Response to the Australian Productivity Commission's Draft Report on Mental Health' accessible at <https://www.pc.gov.au/__data/assets/pdf_file/0015/251115/sub882-mental-health.pdf> [accessed 6 July 2020].

How Victoria might continue to respond to the mental health ramifications of COVID-19

68 The framework set out in the National Mental Health and Wellbeing Pandemic Response Plan provides an excellent basis upon which to consider the effectiveness and value of current mental health initiatives and to plan for additional ones.[78]

69 The ongoing ten key priority areas described in the Plan are:

(a) "Meeting immediate mental health and well-being needs by adapting current services and proactively engaging with those in need.

(b) Implementing new models of care to meet emerging needs that focus on strengthening our communities and community-based care.

(c) Facilitating access to care through coordination and integration.

(d) Addressing complex needs of those with severe, chronic or acute mental illness in ways that promote best practice care, assertively reach out to those who are ill, decrease reliance on inpatient services and increase services within the home and community.

(e) Reducing risk by focusing on mental health and suicide risk factors in their full social context.

(f) Meeting the needs of our most at risk with targeted responses that acknowledge the unique experiences and diverse requirements of vulnerable populations.

(g) Communicating clearly with strategies that inform, provide consistent messages and use community communication as a prevention tool.

(h) A specific focus on coordinated suicide prevention action facilitating a community-wide, cross-sector response.

(i) Supporting a multidisciplinary mental health workforce that recognises the value of lived experience, community and clinical professionals in delivering the quality and quantity of care required.

(j) Providing strong governance and integrated coordination of Australia's federated mental health system to drive implementation."[79]

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[78] Australian Government, 'National Mental Health and Wellbeing Pandemic Response Plan', May 2020, <https://www.mentalhealthcommission.gov.au/getmedia/1b7405ce-5d1a-44fc-b1e9-c00204614cb5/National-Mental-Health-and-Wellbeing-Pandemic-Response-Plan> [accessed 3 June 2020]. As noted above, this National Plan has been developed under the co-leadership of Victoria, New South Wales and the Commonwealth.

[79] Ibid at p. 5. For more detail on the ongoing key priority areas, see pp. 14-37 of the Plan. Appendix A to the Plan provides a summary of these key priority areas.

70 Of particular relevance to the Victorian Government is the section in the Plan on governance and integrated coordination (at pages 36-37), which calls on the States, Territories and the Commonwealth to ensure that:

(a) there are improvements in collaboration and cooperation between health departments;

(b) the Mental Health Principal Committee will be empowered to be the Implementation Governance Committee for the Plan; and, very importantly

(c) the newly formed National Cabinet will oversee the Plan during the response phase.[80]

71 If either a Deputy Chief Medical Officer – Mental Health or a Chief Mental Health Officer was appointed with a role at the State Government level, similar to the current Deputy Chief Medical Officer for Mental Health role within the Commonwealth Government (please see paragraph 62 above), the appointee would augment the important work currently being carried out within the DHHS by the COVID-19 Mental Health team. My understanding is that the latter team's work involves a response to the pandemic itself, dealing with mental health consequences of isolation in returned travellers and others who have been quarantined (mainly in hotels) in Victoria[81] and planning for the recovery. The establishment and maintenance of a detailed and responsive database has been and will continue to be very important in relation to these activities.

Longer term opportunities for service delivery arising from COVID-19

72 In my view, the COVID-19 crisis will cause us to recognise that there are people in our society for whom we can do much more. An example of this is that people who are homeless or sleeping rough are being provided with accommodation at much higher rates than before this crisis.[82] This is of benefit not only to these individuals but to society as a whole.

73 COVID-19 also presents an opportunity for developing more understanding and empathy about what it is like to live with symptoms of mental distress, such as anxiety. As noted above, recent surveys indicate increased levels of anxiety in the community. It is generally easier to allow to go unnoticed feelings like anxiety, depression and dread when they are being experienced by other people. The fact that more people are feeling anxious and

[80] Australian Government, Department of Prime Minister and Cabinet, 'COAG becomes National Cabinet',2 June 2020, <https://www.pmc.gov.au/news-centre/government/coag-becomes-national-cabinet> [accessed 1 July 2020].
[81] There are an estimated 18,000 returned travellers and others who have been quarantined in Victoria, according to an interview with Professor Brett Sutton, Chief Health Officer, Radio National Health Report, 30 June 2020.
[82] See paragraph 150 below.

depressed themselves may make it easier to imagine what life is like for people who are in an anxious state most of their lives.

74 While there is better awareness of anxiety and depression, in my view other forms of psychiatric illness are still far from being on the community radar. The plight of people who have serious mental illness is especially under-recognised among the general public. This means that there is even more reason to 'double down' on taking steps to improve community awareness of serious mental illness and the need to take major, practical steps to help people with these illnesses.

Telehealth and other technology – opportunities and barriers

75 There is widespread consensus that COVID-19 will have permanent positive effects for the way that mental health care is delivered. There will be a recognition that our society can do things we never thought possible, with the clearest example being the increasing adoption of telehealth.

76 Mental health workers and patients are becoming increasingly comfortable with using technology such as telehealth to deliver and receive services. Some people have already been using this technology for some time already, especially in rural and regional communities. However, on the whole telehealth has not been the preferred mode of interaction and, in my view, even though its use will undoubtedly increase, it will not become the preferred mode across the board. While telehealth has many advantages, in my view, face-to-face interactions are superior with regard to the comfort, immediacy and ebb and flow of interpersonal discourse, the development of the therapeutic alliance, and the reciprocal ability to assess the nuances of both the patient's and the mental health professional's emotional state. Face-to-face consultations are especially important in initial assessments and in consultations involving a highly distressed patient, when escalation of the level of care may be considered.

77 The Commonwealth Government has also taken a more 'permissive' attitude towards billing of telehealth consultations through the Medicare Benefits Scheme (**MBS**). There are 18 new MBS items for psychiatrists to have telehealth consultations (by phone or video). The Commonwealth Government may develop an increasing appetite for telehealth modes of delivery, even after the pandemic.

78 As to the dramatic acceleration of telehealth mental health services during the COVID-19 pandemic, the Centre for Online Health at the University of Queensland reports that:

(a) from March 2020, there have been more than 7 million MBS-funded telehealth consultations, with 91% of those consultations being conducted by phone; and

(b) over the same period, mental health consultations conducted by phone and videoconference by non-psychiatrists—including psychologists, social workers and GPs— increased by 50%. In April 2020, 26% of consultations by psychiatrists were telehealth ones, in contrast to 4.5% pre-COVID-19.[83]

79 One barrier to telehealth and other technology is that people who are living in straitened circumstances may not be able to access these modes of service delivery. For example, people who are homeless or living in a boarding house may not have access to their own phone or to computers with reliable, private internet connections. It will be very important to ensure that alternate methods of accessing mental health services are provided to people who may ideally engage in telehealth consultations but are unable to do so. These alternate methods could including providing people in this group with suitable communication tools, or the option to be seen in person, for example by means of assertive outreach.

Preparing for the future: Long term planning for both COVID-19 and other pandemics

80 The context for considering the development of policy recommendations regarding the mental health aspects of COVID-19 at the State level must include two broader considerations, amongst many others – namely:

(a) For how long might Victoria need to take special public health precautions to protect against the spread of COVID-19?

(b) To what extent should Victoria be in a state of preparedness for future pandemics?

I address each of these questions below.

<u>Long term need for special public health precautions</u>

81 For the reasons set out below, in my opinion, there will be a need to anticipate, even with a considerable degree of optimism, at least a baseline of COVID-19-related public health

[83] University of Queensland Centre for Health Services Research, 'Telehealth in lockdown mean 7 million fewer chances to transmit the coronavirus', 23 June 2020, <https://chsr.centre.uq.edu.au/article/2020/06/telehealth-lockdown-meant-7-million-fewer-chances-transmit-coronavirus> [accessed 1 July 2020]. See also Katie Burgess, 'Coronavirus: Telehealth expansion to remain post-pandemic', *The Canberra Times*, 9 June 2020, <https://www.canberratimes.com.au/story/6786471/government-looking-to-keep-expanded-telehealth-hunt/#gsc.tab=0> [accessed 27 June 2020], which quotes Greg Hunt as saying: "We're now at over 13.8 million telehealth services in Australia and a very large percentage of those have been for mental health services".

restrictions to remain in place for a period of at least two further years, but probably more than three years.[84]

82 Although it is likely that effective and safe treatments for COVID-19,[85] especially using re-purposed drugs, will occur earlier than the development of safe and effective vaccines, it will only be after the development of effective vaccination programs that we will be able to dramatically reduce the need for special public health measures in response to the current pandemic. Vaccination is, of course, the vastly preferred method of creating herd immunity in a population, in contrast to natural infection.[86]

83 There is cause for a degree of optimism in relation to vaccine development,[87] given the unprecedented number of vaccine candidates (more than 125 as at 30 June 2020)[88] and the investment in greatly accelerating COVID-19 vaccine research.[89] To illustrate the speed involved, within just over five months of the full genetic sequence of the virus that causes COVID-19 (SARS-CoV-2) being shared with the world by Chinese scientists,[90] as at mid-June 2020 eleven clinical trials of vaccines are in progress, with five in phase two.[91] Despite this optimism, however, it is important to note that vaccine development usually takes at least a decade because all treatments need to pass through several phases of

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[84] I note that internationally renowned subject area experts such as Dr Anthony Fauci, of the US National Institute of Allergy and Infectious Diseases, and Professor Sharon Lewin from the Doherty Institute, have more optimistic outlooks.

[85] As noted above, I was a co-author of two RRIF reports, one on the most promising COVID-19 therapeutics (see letter dated 17 May 2020 available at <https://www.chiefscientist.gov.au/sites/default/files/2020-05/RRIF%20Q009%20Promising%20COVID-19%20Treatments%2017%20May%202020.pdf> [accessed 22 June 2020]) and the other on the most promising vaccines for COVID-19 (see letter dated 11 May 2020 available at <https://www.chiefscientist.gov.au/sites/default/files/2020-05/rrif-covid19-promising-vaccines.pdf> [accessed 22 June 2020].) See also footnote 3 above.

[86] Mayo Clinic, 'Herd immunity and COVID-19 (coronavirus): What you need to know', 6 June 2020, <https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/herd-immunity-and-coronavirus/art-20486808> [accessed 22 June 2020]. The United Kingdom's initial public health response was aimed at developing herd immunity by means of at least 60% of the population becoming infected (the specific mention by the Chief Scientist of the UK promoting this view can been seen at 4.35 minutes in the interview 'UK needs to get COVID-19 for 'herd immunity'', *Sky News*, 13 March 2020, <https://www.youtube.com/watch?v=2XRc389TvG8> [accessed 28 June 2020].

[87] Office of the Chief Scientist of Australia (Lead author: Professor Tony Cunningham), 'RRIF Addendum: corrections and updates – The most promising vaccines for COVID-19', 17 June 2020, <https://www.chiefscientist.gov.au/sites/default/files/2020-06/RRIF%20Q007%20%20Vaccines%20UPDATE%2017%20June%202020.pdf> [accessed 28 June 2020].

[88] Jonathan Corum et al, 'Coronavirus Vaccine Tracker', *The New York Times*, updated 26 June 2020, <https://www.nytimes.com/interactive/2020/science/coronavirus-vaccine-tracker.html> [accessed 30 June 2020]. See also Stuart A Thompson, 'How long will a vaccine really take?', *The New York Times*, 30 April 2020, <https://www.nytimes.com/interactive/2020/04/30/opinion/coronavirus-covid-vaccine.html> [accessed 27 June 2020].

[89] Alana Wise, 'Trump Promises 'Warp Speed' Coronavirus Vaccine Effort with New Program', *NPR*, 15 May 2020, <https://www.npr.org/sections/coronavirus-live-updates/2020/05/15/857014274/trump-touts-operation-warp-speed-coronavirus-vaccine-effort > [accessed 22 June 2020].

[90] Science Daily, 'Whole genome of novel coronavirus, 2019-nCoV, sequenced',11 January 2020, <https://www.sciencedaily.com/releases/2020/01/200131114748.htm> [accessed 30 June 2020].

[91] Office of the Chief Scientist of Australia (Lead author: Professor Tony Cunningham), 'RRIF Addendum: corrections and updates – The most promising vaccines for COVID-19', 17 June 2020, <https://www.chiefscientist.gov.au/sites/default/files/2020-06/RRIF%20Q007%20%20Vaccines%20UPDATE%2017%20June%202020.pdf> [accessed 28 June 2020]. These data are, of course, constantly changing. See also footnote 85 above.

testing (pre-clinical phase 1, phase 2 and phase 3, including essential safety considerations in each phase).[92] On average, vaccine development takes ten years and has a 6% success rate (i.e. a 6% probability of entering the market).[93]

84 In regard to safety, considerable caution needs to be observed when considering the vaccination of billions of people world-wide. It would be challenging to contemplate such wide scale vaccinations on the back of studies of a relatively small number of thousands of people in phase 3 (efficacy and safety phase), with this phase typically taking one to four years under less urgent circumstances.[94] This is particularly the case given that, in order to speed up manufacturing output, vaccinations may involve a number of different vaccines, if they can be shown to be effective and safe. Although hopes are being raised for the deployment of safe and effective vaccinations within 12-18 months, or even sooner, it would seem best to treat such a short timeframe as optimistic and to conduct default planning on considerably longer time frames, including because of:

(a) the need to undertake extensive safety testing on many thousands of people before billions are vaccinated;

(b) the need to scale-up production of safe and effective vaccines to meet worldwide need.[95] In order to try to deal with this issue, a number of groups are in the process of mass-producing millions of doses of vaccines ahead of knowing whether the vaccines will be safe and effective. Two of these types of vaccines, (being gene-based ones, RNA and DNA vaccines) have never been approved for use in humans, let alone having been produced at scale; and

(c) the existence of vaccine nationalism.[96] Because of this phenomenon, Australia may be particularly dependent on the success of the very limited number of potential vaccines being developed in our country, for example the one by the

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[92] National Health and Medical Research Council, 'Phases of clinical trials', 19 February 2015, <https://www.australianclinicaltrials.gov.au/what-clinical-trial/phases-clinical-trials> [accessed 22 June 2020].

[93] Esther S Pronker et al, 'Risk in Vaccine Research and Development Quantified', PLOS ONE, 8.3 (2013), <https://doi.org/10.1371/journal.pone.0057755> [accessed 3 July 2020]. See also Biotechnology Innovation Organisation, Press Release: 'BIO Releases Largest Study Ever on Clinical Development Success Rates', 25 May 2016, <https://www.bio.org/press-release/bio-releases-largest-study-ever-clinical-development-success-rates> [accessed 22 June 2020]. A copy of the full report 'Clinical Development Success Rates 2006-2015' is available for online download at <https://www.bio.org/sites/default/files/legacy/bioorg/docs/Clinical%20Development%20Success%20Rates%202006-2015%20-%20BIO,%20Biomedtracker,%20Amplion%202016.pdf> [accessed 3 July 2020].

[94] Marcos Garcia-Ojeda, 'What needs to go right to get a coronavirus vaccine in 12 to 18 months', *The Conversation*, 8 May 2020, <https://theconversation.com/what-needs-to-go-right-to-get-a-coronavirus-vaccine-in-12-18-months-136816> [accessed 29 June 2020].

[95] Qasim Rafiq and Martina Micheletti, 'Coronavirus vaccine search: how we're preparing to make enough for the whole world', *The Conversation*, 13 May 2020, <https://theconversation.com/coronavirus-vaccine-search-how-were-preparing-to-make-enough-for-the-whole-world-137970> [accessed 27 June 2020].

[96] Ana Santos Rutschman, 'How 'vaccine nationalism' could block vulnerable populations' access to COVID-19 vaccines', *The Conversation*, 17 June 2020, <https://theconversation.com/how-vaccine-nationalism-could-block-vulnerable-populations-access-to-covid-19-vaccines-140689> [accessed 22 June 2020].

University of Queensland,[97] which "relies on a 'molecular clamp' to preserve the shape of the [SARS-CoV-2 type] protein"[98], in order to enhance its ability to elicit an immune response.

85 Of course, despite the efforts to develop a vaccine, and although several candidate vaccines have already been reported as eliciting antibody responses, the hope for a safe and effective vaccine against COVID-19 may fail to ever come to fruition – as has been the case for a vaccine against HIV and against all human coronavirus. Even if that outcome were to eventuate, it could still be possible for COVID-19 to largely disappear from the population over a short time-span, as happened with the deadly influenza epidemic of 1918-1919,[99] especially given the current low rate of COVID-19 in Australia. But this would be dependent on Australia not 'importing' COVID-19 from overseas, by largely remaining isolated from the rest of the world – where there is currently, on the whole, a much higher rate of infection. Such prolonged geographic isolation would continue to be extremely detrimental to Australia's economy.[100]

Preparedness for future pandemics

86 There is clear evidence that there has been an increase in the spread of infections originating in animals to humans – so called "spill-over events".[101] Although just over 200 virus species can infect humans, there are an estimated 631,000 to 870,000 of approximately 1.6 million unknown viruses existing in mammals and birds that may have

[97] The University of Queensland, 'UQ COVID-19 vaccine shown to induce potent protective response in pre-clinical trials' <https://www.uq.edu.au/news/article/2020/04/uq-covid-19-vaccine-shown-induce-potent-protective-response-pre-clinical-trials> [accessed 22 June 2020]; Jo Khan for the Health Report, 'We've never made a successful vaccine for a coronavirus before. This is why it's so difficult', *ABC News*, 17 April 2020, <https://www.abc.net.au/news/health/2020-04-17/coronavirus-vaccine-ian-frazer/12146616> [accessed 22 June 2020].

[98] Office of the Chief Scientist of Australia, Lead author: Professor Tony Cunningham, 'RRIF Addendum: corrections and updates – The most promising vaccines for COVID-19' 17 June 2020, <https://www.chiefscientist.gov.au/sites/default/files/2020-06/RRIF%20Q007%20%20Vaccines%20UPDATE%2017%20June%202020.pdf> [accessed 30 June 2020] at p. 7.

[99] See Peter Curson and Kevin McCracken, 'An Australian perspective of the 1918-1919 influenza pandemic', *NSW Public Health Bulletin*, 17.7-8 (2006), 103-107, available at <https://www.publish.csiro.au/nb/pdf/NB06025> [accessed 22 June 2020].

[100] See for example Bessie Hassan, 'RBA survey: 87% experts say international borders to remain closed until 2021', *Finder*, 4 May 2020, <https://www.finder.com.au/press-release-may-2020-rba-survey-87-experts-say-international-borders-to-remain-closed-until-2021> [accessed 4 July 2020] and the discussion in Evan Young, 'Coronavirus has halted immigration to Australia and that has experts worried about the country's economic and social recovery from the pandemic', *SBS News*, 1 May 2020, available at <https://www.sbs.com.au/news/coronavirus-has-halted-immigration-to-australia-and-that-could-have-dire-consequences-for-its-economic-recovery> [accessed 22 June 2020]; John Kehoe, 'What an 85pc fall in migration means for the economy and housing', *Australian Financial Review*, 1 May 2020, available at <https://www.afr.com/policy/economy/later-migration-plunge-to-hurt-economy-and-housing-20200501-p54p2g> [accessed 22 June 2020].

[101] Stacey McKenna, 'Human Viruses Can Jump into Animals, Too—Sowing the Seeds of Future Epidemics', *Scientific American*, 20 May 2020, <https://www.scientificamerican.com/article/human-viruses-can-jump-into-animals-too-sowing-the-seeds-of-future-epidemics/> [accessed 22 June 2020]; Katherine F Smith et al, 'Global rise in human infectious disease outbreaks', *Journal of the Royal Society Interface*, 11.101 (2014) <http://dx.doi.org/10.1098/rsif.2014.0950> [accessed 3 July 2020].

the capacity to infect people.[102] The cause for the increase in these zoonotic diseases (infections that pass from animals to people) has been attributed to alterations in ecosystems, to the exploitation of wildlife and to increasing global connectedness.[103]

87 To put this into perspective, especially in light of the relative numbers of past and current zoonotic infections in comparison to the potential number of such infections, spill-over events remain exceedingly rare. Nevertheless, given the 'wake-up call' that has been provided by the current pandemic and the increasing rate of zoonotic infections, it will be essential for Australia to be in a state of heightened pandemic preparedness forevermore. This reality has multiple policy implications for Victoria's mental health care system, including in terms of:

(a) the need to strengthen infection control protocols;

(b) the provision and stockpiling of sufficient supplies of Personal Protective Equipment;

(c) new ways of thinking about the design of psychiatric facilities;

(d) strengthening the links between the public and private health sectors (which has been a notable feature in non-mental health areas in the wake of COVID-19); and

(e) preparing for and adapting to future budgetary shocks.

88 Whether success is reached in relation to a vaccine or not, it is clear that Australia needs to have heightened pandemic preparedness, including with respect to mental health care. There are several reasons for this need, including the fact that South East Asian countries that had a much greater exposure to the 2003 SARS epidemic than Australia and a number of countries, in general had a much more effective and faster response than many other countries, especially the United States, Brazil, Italy and Spain. We are seeing a similar pattern with COVID-19. For example, Taiwan has a similar population to Australia and, as at 22 June 2020, had 446 cases of COVID-19 and seven deaths, in comparison to Australia's 7,474 cases and 102 deaths. Similar to other low COVID-19 prevalence countries in South East Asia, Taiwan took early action in the form of travel bans, increasing mask production and the intensive use of technology to identify and trace infection.[104]

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[102] Dennis Carroll et al, 'The Global Virome Project', Science, 359.6378 (2018), 872-874 at p. 874.
[103] Martin A. Nuñez, Anibal Pauchard and Anthony Ricciardi, 'Invasion Science and the Global Spread of SARS-CoV-2', *Trends in Ecology and Evolution*, 2020 (Article in Press) <https://www.sciencedirect.com/science/article/pii/S0169534720301348> [accessed 22 June 2020].
[104] William Yang, 'How has Taiwan kept its coronavirus infection rate so low?', *Deutsche Welle*, 9 April 2020 <https://www.dw.com/en/taiwan-coronavirus/a-52724523> [accessed 22 June 2020].

89 Regardless of the success or otherwise of Victoria's and Australia's management of the current pandemic, it is clear that forevermore we need to be in an ongoing state of preparedness for the inevitability of future pandemics.[105]

Characteristics of a future mental health system

A note on terminology: De-hospitalisation and bed care

De-hospitalisation

90 Opponents of specialist hospitals for mental health use the terms institutionalisation or de-institutionalisation. I prefer to use the term de-hospitalisation rather than de-institutionalisation. The term de-institutionalisation implies that you cannot have a psychiatric hospital without it being an 'institution'; I disagree with that proposition. By way of analogy, if we were to close the Royal Children's Hospital, we would not primarily be contributing to a de-institutionalisation of paediatric care; rather, we would be contributing to a de-hospitalisation of such care.

91 I comment below on the era of de-hospitalisation and its impacts; in doing so, I am not critical of the closure of many sub-standard psychiatric hospitals, although in some cases a major upgrade or rebuilding of at least a small number of hospitals should have occurred instead of the closure and non-replacement of all of them, just as the Peter MacCallum Cancer Centre and The Royal Women's Hospital were rebuilt and are now located in outstandingly good buildings.[106] In saying this, I also strongly acknowledge that there have been many advantages in treating people with psychiatric illness in general hospitals, including medical care for patients and improvements in de-stigmatisation.

Providing adequate inpatient care; and the use of the term "psychiatric beds"

92 In addition, some of the discussion about mental health system reform focuses on dry numerical exercises around bed numbers. We therefore need to unpack what we mean when we talk about "beds".

93 When we talk about "psychiatric beds" in mental health care, it is important to emphasise that we are not talking about hospital furniture; "psychiatric beds" is a shorthand term for a mechanism by which an appropriate and more intensive level of care can be provided in inpatient settings for people whose needs are unable to be met by care in the

[105] Although I am not involved in providing inpatient care to psychiatric patients in either public or private psychiatric hospitals, and although there is some literature on infection control in psychiatric facilities (see for example Yuriko Fukuta and Robert R Muder, 'Infections in Psychiatric Facilities, with an Emphasis on Outbreaks' *Infection Control and Hospital Epidemiology*, 34.1(2013), 80-88, https://doi.org/10.1086/668774 [accessed 6 July 2020]), it is my impression from speaking to colleagues that until COVID-19, infection control has not been, but will now need to be, a 'top of mind' issue in psychiatric facilities.

[106] The 'old' Peter MacCallum Cancer Centre in East Melbourne and the 'old' Royal Women's Hospital in Carlton, were much better facilities than the psychiatric hospitals that were closed down in the 1990s.

community – especially those who have severe mental illness and who may be either experiencing that for the first time at a high level of acuity or are having major relapses or are in danger of seriously harming themselves or others, or a combination of these circumstances. We are often talking about providing care, at the appropriate level, for people who have psychotic illnesses or bipolar or related disorders. We are often talking about care for people whose mental state has deteriorated to a point where their ability to look after themselves has declined dramatically.

Summary of key components of the future provision of inpatient, outpatient and community care

94 I consider that a future mental health system in Victoria in 10 years' time should ensure that:

(a) a well-resourced, seamless and closely inter-linked combination of community, outpatient and inpatient care is provided to people within our society;

(b) there is a substantial increase in the provision of inpatient treatment for those who require it, especially for those who require high-dependency care;

(c) in addition to pharmacological support, hospital inpatients are provided with all of the services and psychosocial supports that can be provided within a hospital environment to promote recovery;

(d) there is parity of care and parity of esteem – the quality of care for people with psychiatric illness should be commensurate with their needs. Just as people with serious illnesses such as cancer, cardiac failure or neurodegenerative disorders receive the best care possible, so too should people with mental illnesses—especially those at the severe end of the mental health/illness spectrum—receive the level and quality of care that they require and deserve;

(e) there is greater integration of primary and specialist care, particularly for people who are marginalised. Mental Health Integrated Services Hubs should be established to promote this system integration;[107]

(f) there are more opportunities for outpatient psychiatric treatment. We know from other areas of medicine, such as respiratory medicine and rheumatology, that outpatient clinics offer good economies of scale. Outpatient psychiatric clinics would also allow patients to have more regular contact with psychiatrists;

(g) there is a substantial increase in the delivery of community based mental health care;

[107] I discuss the importance of integrated and continuing care and service hubs at paragraphs 115 to 122 below.

(h) there is an introduction (or reintroduction in some cases) of significantly under-utilised therapeutic modalities of mental health care, including psychotherapies. This should be a particular focus in public hospitals where this kind of therapy is lacking;

(i) there are more, and more appropriate, options for longer-term care and accommodation, both in specialist mental health centres and in the community;

(j) an equivalent level of care should be provided to people who can afford private hospital psychiatric care *and* people receiving care in the public sector. There needs to be better integration with the private system and better utilisation of the capacity of the private system;

(k) we recruit and retain significantly more people into the mental health workforce;

(l) there is reduced red tape and less paperwork, meaning a lower administrative burden on mental health workers. The productivity of community mental health workers, in terms of face-to-face contact, is currently lower than it should be because of the high administrative burden – too much time is spent with paperwork and not enough time is spent with patients; and

(m) there is careful monitoring of the outcomes of mental health reforms across a wide range of agreed indices. This outcome measurement should be coupled with high-quality clinical information systems, as well as long-term care coordination and monitoring for people with severe mental illness.[108]

95 Further, it is my aspiration that the Victorian Mental Health System of the future incorporates:

(a) the very best elements that are present in mental health care systems elsewhere in the world, with Germany being an exemplar that I refer to below. The German psychiatric system is comparatively well-funded, with much better provision of outpatient and inpatient care, much lower rates of compulsory admission and centres of excellence which combine clinical care, research and the education of mental health professionals.

(b) national and international benchmarking. Just as universities and hospital cities are ranked, I consider there should also be a ranking of mental health care systems around the world, and those rankings should be taken very seriously,[109] It is my view that Victoria could play a lead role in linking our State into a comprehensive and international mental health benchmarking exercise. This will be one step in ensuring we start making what is likely to be a slow, but imperative,

[108] I discuss outcome and performance monitoring further from paragraph 168 below.
[109] One of the most influential university rankings is the Academic Ranking of World Universities <http://www.shanghairanking.com/> [accessed 1 July 2020]. As to hospital cities, see <https://www.medbelle.com/best-hospital-cities-world> [accessed 1 July 2020].

journey towards having a mental health system that we can be proud of. As a nation, we do not take a sufficiently internationalist approach to mental health. All nations have much to learn from one another regarding the best approaches that are needed to improve outcomes, especially for those with serious mental disorders. Examples of successful approaches to mental health issues in other countries include the work in Denmark to reduce suicide,[110] the work in Germany to mandate levels of care (which I discuss from paragraph 165 below) and the work in Finland to reduce the level of homelessness (I discuss the link between homelessness and mental illness from paragraph 146 below);

(c) high quality elements that are present in the Australian private psychiatric sector in terms of personalisation and continuity of care by clinicians at various levels of seniority, who are comparatively unburdened by heavy administrative responsibilities.[111] There should also be higher rates of access to a range of programs including day patient and disorder-specific programs, admissions without the need for attendance at, and often long stays in, Emergency Departments (noting that private psychiatric hospitals do not have Emergency Departments) and inpatient care with greater lengths of stay – as required;

(d) a level of quality of services that is found within specialist components of the Victorian Mental Health and Alcohol Service system, such as the Statewide Neuropsychiatry Service (based at the Royal Melbourne Hospital), Orygen, Spectrum, the Fixed Threat Assessment Centre, the Bouverie Centre (family-based therapy) and Turning Point; and

(e) the best that the system had to offer in the past, including the Community Mental Health Service Programs of the early 2000s, which were comparatively well-funded, "with a case management model, supported by sufficient and timely access to intensive outreach and to inpatient care."[112]

A brief overview of de-hospitalisation and reduction in bed-based care

96 To better understand why there are shortfalls in particular areas of the current mental health system, and to consider the future mental health system, we need to first understand the past.

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[110] Merete Nordentoft and Annette Erlangsen, 'Suicide – turning the tide' *Science,* 365.6455 (2019), 725, <https://science.sciencemag.org/content/365/6455/725> [accessed 8 June 2020].

[111] At the same time, there should be ongoing recognition that the public mental health system has comparative strengths in multidisciplinary team approaches to patient care, as well as community outreach, and has obligations to assess and care for those who require compulsory admission under the *Mental Health Act 2014* (Vic).

[112] TAPI Submission, p. 36 and see the reference cited therein.

97 In the 1960s, there were around 30,000 inpatient beds in specialist psychiatric hospitals for adults and older people.[113] In 1992 just prior to de-hospitalisation, Victoria had 2,087 such beds.[114]

98 Willsmere Hospital was the first psychiatric hospital to be decommissioned in Victoria, in 1988. A clinical audit of the existing hospitals conducted in 1992 showed that "the quality of inpatient treatment and care was unacceptably uneven, and fell below required standards in many adult extended care wards".[115] As a result, Victoria closed all 14 standalone psychiatric hospitals with the eventual exception of what became the Thomas Embling Hospital in 2000. People were transferred from these specialist hospitals into general hospital wards. Even taking into account those transfers, between 1993 and 2000 there was a 31% per cent per capita reduction in the number of public sector psychiatric beds in Australia.[116]

99 The Australian population has significantly increased since the de-hospitalisation era (by more than 45%, from 17,482,593 in 1992[117] to 25,522,169 in 2019[118]), yet there has not been a corresponding increase in the number of psychiatric beds in general hospitals and stand-alone psychiatric hospitals; rather, there has been a reduction – from 7,991 beds in 1992-93[119] to 6,920 beds in 2017-18.[120] This means that since 1992, the number of psychiatric beds has reduced from 45.5 beds per 100,000 of the population to 27.9 beds per 100,000 of the population – a 40% per capita reduction, with Victoria having the lowest

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[113] Australian Government, 'National Mental Health Report 2007', p. 36. While the online version of this report has been archived, a copy can be accessed at <https://web.archive.org.au/awa/20141216090509mp_/http:/www.mbsonline.gov.au/internet/main/publishing.nsf/Content/67964377F1D689ADCA257BF00021E0BF/$File/report07.pdf> [accessed 2 June 2020].

[114] Valerie Gerrand 'Can deinstitutionalisation work? Mental health reform from 1993 to 1998 in Victoria, Australia', Health Sociology Review, 14.3 (2005), 255 at p. 259. In my view, this paper provides a very helpful overview of the history of the de-hospitalisation of the mental health system that occurred in Victoria during the mid-1990s.

[115] Ibid. at 258 (citations omitted).

[116] Australian Government, 'National Mental Health Report', 2004, p. 22. While the online version of this report has been archived, a copy can be accessed at <https://web.archive.org.au/awa/20140213173255mp_/http://www.health.gov.au/internet/main/publishing.nsf/Content/11DB1084AF5CDBAACA257BF000211F39/$File/report04.pdf> [accessed 2 June 2020].

[117] Australian Bureau of Statistics, 'Catalogue No. 3220.0 Estimated Resident Population By Marital Status, Age and Sex, Australia, Preliminary June 1992 and June 1993' (1994) <https://www.ausstats.abs.gov.au/ausstats/free.nsf/0/6A6713D80070D42ECA257225000494C3/$File/32200_0692.pdf> [accessed 1 June 2020] at page 7.

[118] Australian Bureau of Statistics, '3101.0 - Australian Demographic Statistics, Dec 2019',2020, <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3101.0Main+Features1Dec%202019?OpenDocument> [accessed 1 July 2020].

[119] This figure is the combined total of the number of public psychiatric beds in stand-alone hospitals in 1992-93 (n=5,802) and in general hospitals in the same year (n=2,189), Department of Health, 'National Mental Health Report 2013: Changes in inpatient services' <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-report13-toc~mental-pubs-n-report13-2~mental-pubs-n-report13-2-4~mental-pubs-n-report13-2-4-cha> [accessed 1 June 2020].

[120] AIHW, 'Specialised mental health care facilities', last updated January 2020, <https://www.aihw.gov.au/getmedia/cda9685e-445e-4217-bdf9-c57c3baaac55/Specialised-mental-health-care-facilities-2017-18.pdf.aspx> [accessed 1 June 2020] at Table FAC.12.

per capita number of psychiatric beds (22.3 per 100,000 of the population) of all Australian states and territories.[121]

100 Just over 50% of inpatients in 1992 required extended psychiatric care.[122] In other words, in 1992 approximately 1,000 Victorians needed extended care for psychiatric disorders. Based on population growth, we can extrapolate that there are 1,500 Victorians currently in need of extended care for psychiatric disorders.[123] There is no evidence to suggest that there has been a decrease in the rate of serious mental illness since 1992. Yet we currently have only 136 beds in Secure Extended Care Units (**SECU**s).[124] It is my view that the under-recognition of the natural history of people with enduring psychotic illnesses who have multiple and complex needs, and the lack of suitable provision for their needs in the Victorian Mental Health Framework,[125] notwithstanding the provision of care and accommodation in the community, has had reverberating, long-standing and negative effects.

101 In my view, a cluster of forces and factors led to the view in Australia that psychiatric hospital beds should be reduced, including neoliberalism, fiscal conservatism and the anti-psychiatry movement.

102 Some practitioners, academics, clients and advocates continue to argue that having a high number of inpatient beds comes at the expense of community psychiatry, or vice versa (i.e. that high levels of community psychiatry and outpatient hospital psychiatry come at the expense of inpatient hospital beds). As a paper by Isabel Perera demonstrates, and as I explain below, that notion is a fallacy.[126]

103 There needs to be high quality provision of *both* inpatient beds and outpatient/community services. There should not be a 'competition' between the two components of care; rather, the two systems need to grow 'in tandem' and should be interlinked and synergistic. The

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[121] Ibid. at Table FAC.13.
[122] Valerie Gerrand, 'Can deinstitutionalisation work? Mental health reform from 1993 to 1998 in Victoria, Australia', *Health Sociology Review*, 14.3 (2005), 255 at p. 259.
[123] ABS data indicate that the population of Victoria has increased approximately 50% since 1992 – the Victorian population was 4.45 million in 1992 and 6.63 million in 2019. See Australian Bureau of Statistics, '3101.0 - Australian Demographic Statistics, Sep 2019' <https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3101.0Sep%202019?OpenDocument> [accessed 6 July 2020] at Table 4, data series A2060844K.
[124] AIHW, 'Specialised mental health care facilities 2017–18 tables' <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-mental-health-care-facilities> [accessed 1 July 2020] at Table FAC.14.
[125] Psychiatric Services Division, Dept. of Victorian Government Dept. of Health and Community Services, 'Victoria's mental health services: the framework for service delivery', 1994.
[126] Isabel M Perera, 'The Relationship Between Hospital and Community Psychiatry: Complements, Not Substitutes?', *Psychiatric Services*, 2020, <https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201900086>. In this paper, Perera draws on cross-national data from the World Health Organization.

German mental health system provides a best practice example of this synergistic approach.[127]

The importance of combining inpatient and outpatient/community care

104 The 1992 audit I mentioned above also found that 80% of the people who were in psychiatric hospitals had no connection with any form of community mental health care.[128] That figure is unsurprising as community mental health services only received 26% of the mental health budget at that time.[129] There was subsequently an increase in the portion of public mental health expenditure spent on community mental health.[130] In my view, the majority of funding should go into community support. I consider it is preferable for people to be treated in the community, if that is possible, and is effective and safe.

105 In Europe there has for many years been a recognition that both community care and hospital care need to go together. Countries such as Switzerland, Germany, Belgium, France and the Netherlands have a combination of both care in the community and care in hospital. In high quality mental health systems such as these, it is not a question of inpatient care *versus* community/outpatient care. Rather, both forms of care are appropriately provided and they go along in tandem; they are complementary, not competitive.[131]

Care in the public versus private system

106 Inpatient care in the public mental health system is based primarily on risk management, rather than care and recovery.

107 Currently, public hospital Emergency Departments are crisis areas and we have a deficiency of some hundreds of beds in Victoria. Emergency Departments are not therapeutic environments for people with psychiatric illness, especially not for those who are in crisis. If there was an adequate number of inpatient mental health beds, it would be preferable for many patients to go directly from the community into public mental health

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[127] For an overview of the key reforms to the mental health care system introduced in Germany during the 1990s and the early 2000s, see Hans Joachim Salize, Wuf Rossler and Thomas Becker, 'Mental health care in Germany'. *European Archives of Psychiatry and Clinical Neuroscience*, 257.2(2007), 92-103. Germany's mental health system was ranked first out of 30 European countries assessed in the report: The Economist Intelligence Unit, Mental Health and Integration: Provision for supporting people with mental illness: A comparison of 30 European Countries, 2014.

[128] Valerie Gerrand 'Can deinstitutionalisation work? Mental health reform from 1993 to 1998 in Victoria', Australia, Health Sociology Review, 14.3 (2005), 255 at p. 258.

[129] Ibid. at 259.

[130] Alan Rosen, 'Australia's national mental health strategy in historical perspective: beyond the frontier', International Journal of Psychiatry, 3.4 (2006), 19-21. See Figure 1 on p. 19 <https://www.ncbi.nlm.nih.gov/pmc/articles/pmid/31507866/> [accessed 9 June 2020]. See also the Royal Commission's Interim Report, page 74, Figure 3.3; and the Victorian Government's submission to the Royal Commission, p. 9, Figure 2, <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/5215/6514/1027/Victorian_Government.pdf> [accessed 1 July 2020].

[131] Isabel M Perera, 'The Relationship Between Hospital and Community Psychiatry: Complements, Not Substitutes?' *Psychiatric Services*, pp. appi-ps.

beds. This currently occurs in Australian private psychiatric hospitals and also occurs overseas for subsets of patients in countries such as Germany in the public sector (see paragraph 103 above).

108 The vast majority of Australians who do not have private health insurance are unable to be admitted to public mental health facilities unless they pose a clear risk to themselves or others. People who do not meet that threshold may well be seriously unwell and in need of inpatient care.[132] These patients are not afforded the chance to get better as a result of the expert care provided during a hospital admission.

109 In contrast, people who do have private hospital cover can be admitted to private psychiatric hospitals. These people generally have severe conditions, although of a different diagnostic mix to people admitted to the public mental health system – with mainly mood disorders, whereas in the public system, there is a much higher proportion of people admitted with schizophrenia and related disorders. People admitted to private psychiatric hospitals – like those admitted to public hospitals – might have concomitant medical conditions, as well as serious complications from their medications. They might need diagnostic assessment because their level of distress is high, but it is not clear why. This care can be given to them in the private hospital. Victorians who are unable to pay for private health insurance, but are similarly unwell should receive similar levels of care in the public mental health system even though they may not be a risk to themselves or others.[133]

110 In addition, private hospitals tend to offer tend a much wider array of therapeutic programs and psychosocial support for patients than public hospitals, including day hospital programs, group therapy, and various forms of psychotherapy, including cognitive behaviour therapy, Acceptance and Commitment Therapy, Dialectical Behaviour Therapy, Mindfulness and Art Therapy. There is generally not enough time in public hospitals to offer much, if any, of this treatment and support. That too should change, so that there is parity of mental health care in the public and private systems.

Constraints on public psychiatrists

111 From my observations and discussions, another contrast between the public and private mental health systems is that psychiatrists working in the public system sometimes feel constrained to speak out about any problems that exist within the public mental health system, such as under-resourcing. This may have to do with 'self-censorship' or

[132] For information about the clinical circumstances in which patients are admitted into private psychiatric hospitals, see Tables 1 and 3 in Nicholas A Keks et al, 'Characteristics, diagnoses, illness course and risk profiles of inpatients admitted for at least 21 days to an Australian private psychiatric hospital', *Australasian Psychiatry* 27.1 (2019) 25-31.

[133] See also the discussion of strengthening the engagement between the private and public mental health sectors in the TAPI Submission, Section 6.3. See also the discussion about the possible impacts of the COVID-19 pandemic on private health insurance, from paragraph 66 above.

requirements set by the services in which they work to not make critical public statements. Constraints on the ability to speak out, sub-optimal working conditions and generally lower remuneration than in the private sector drive people to private work from the public sector.[134]

The need for a recovery focus

112 My understanding from public sector psychiatrists is that the current discharge process is essentially to discharge 'the least unwell' patients, as opposed to discharging those who are 'well'. That is, public hospitals tend to discharge patients when their risk to themselves or others has diminished to below a certain threshold. Mental health staff, patients and carers should be preparing for a patient's discharge almost as soon as they are admitted, but that does not mean patients should be discharged prematurely.

113 We need to focus more on recovery, therapy and patient autonomy. From my observation, mental health workers—including nurses, social workers and psychiatrists—want to be much more involved in helping patients get better before they are discharged. If a person requires hospitalisation,[135] there should be an option for them to be in a recovery-oriented, retreat-like environment and to be given time to properly recover before returning home, rather than being discharged because they are the 'least unwell' person in the ward.

114 Mental health workers in public hospitals need to be better supported and equipped to employ a recovery focus and help give patients the tools to plan for their future with professional help.

The importance of integrated and continuing care and service hubs

115 Anecdotally, I understand that many General Practitioners (**GP**s) find it very difficult to get specialist mental health input, particularly from psychiatrists. It would be helpful if primary care providers could more easily access mental health experts for advice, for example through telehealth consultations.

116 There is also a very significant need for improved communication between GPs and State mental health services.

117 There needs to be much better integration of mental health within the broader health sector and indeed beyond the health sector. I expect that, in a reformed Victorian mental health system, an increasingly important role will be played by general practitioners in caring for people with mental health needs, with *input* from mental health professionals.

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[134] RANZCP, 'Psychiatry Workforce Report', <https://www.ranzcp.org/files/branches/victoria/ranzcp-vic-psychiatry-workforce-report.aspx> [accessed 17 June 2020], see in particular R50 discussed at p. 67.
[135] There is a range of reasons a person may require hospitalisation, as outline in the TAPI Submission at pp. 39-42.

118 For these reasons, my colleagues at TAPI and I recommend the establishment of Mental Health Integrated Services Hubs (MHISHs in the TAPI Submission, which I will abbreviate here as **Integration Hubs**). The purpose of these Integration Hubs would be:

> "to promote system integration across structural boundaries and to encourage collaborative approaches to evidence-based service development. They should help to coordinate service delivery options across the spectrum of health care providers and enable clearer care pathways between adult community mental health teams, Primary Health Networks, and primary care facilities."[136]

119 We propose that the Integration Hubs would be similar to the highly successful Integrated Cancer Services (**ICS**s) that currently exist in Victoria. Just as the National Disability Insurance Scheme (**NDIS**) is a model for unification of the sector,[137] ICSs are a best practice model for:

(a) enhanced integration of service delivery in the community, for outpatients, and for inpatients; and

(b) linking up services not just within the mental health sector but also between sectors, including housing support, legal services, social support and financial services.

120 Integration Hubs should also have a role in ensuring continuity of care, especially for people with severe mental illness.

121 Careful monitoring of people's mental state and general state of wellbeing, including their financial wellbeing and their employment status, can help mental health professionals to modify treatment options to provide better quality care. As we recommend in the TAPI Submission:

> "Continuity of care – without discharge from the service – should be used as a guiding principle for the small proportion of adults with the most severe forms of serious mental illness, emulating and building on the principles embedded within the current clozapine coordination system." (Recommendation 14)

<u>People with severe mental illness</u>

122 There should be a follow up system of care especially for people with the most severe mental illness, similar to the current clozapine coordinating model of care for people with treatment resistant schizophrenia. There is evidence that the reason clozapine may be associated with a significant lowering of mortality is not just because of the

[136] TAPI Submission, Section 6.1 (particularly pp. 64-65).
[137] See the discussion of what we can learn from the early history of the NDIS from paragraph 295 below.

pharmacological properties of the medication; but also because of the intensive and regular monitoring of blood tests, continuity of care and care coordination, which means that people have contact with clinicians on a regular basis.[138] This issue is discussed in detail in the TAPI Submission at pages 65 to 67.

Quantifying the need for acute and non-acute mental health beds in Victoria

123 Some critics of TAPI might wish to claim that we want to re-open the psychiatric hospitals of yesteryear with similar numbers of psychiatric beds to the middle of the 20th century and that we wish to hospitalise large numbers with mental illness. That is definitely not the case. By way of illustration, the Royal Commission's Interim Report estimates that 205,000 people in Victoria have severe mental illness.[139] As at 2017/2018, Victoria has 1,424 mental health beds—acute and non-acute—for all age groups.[140] Therefore, of those 205,000 people, a maximum of 1,424 people would be inpatients in hospital at any given time. That means that 99.3 out of every 100 people with severe mental illness are *not* in a hospital bed at any given time. If we doubled the number of beds, that would mean that 98.6 out of every 100 people in this cohort would not be in a hospital bed. In other words, there would still be only ~ one person out of every 100 people with severe mental illness receiving inpatient care. This is hardly tantamount to recommending that provision be made for hospitals to be able to admit a large percentage of people with serious mental illness.

124 Further, at least 4,000 Victorians have ultra-treatment resistant psychotic illnesses.[141] These are people who do not respond to or have only a minimal response to clozapine

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[138] See the discussion of 'Long-term care coordination models for severe mental illness – important lessons from clozapine care coordination' in the TAPI Submission, Section 6.1 (particularly at pp. 65-67) and the references cited therein, particularly Tiihonen, Jari, Jouko Lönnqvist, Kristian Wahlbeck, Timo Klaukka, Leo Niskanen, Antti Tanskanen, and Jari Haukka. "11-Year Follow-up of Mortality in Patients with Schizophrenia: A Population-Based Cohort Study (Fin11 Study)." *The Lancet* 374.9690 (2009), 620-27.

[139] Interim Report, pp.27-8.

[140] AIHW, 'Specialised mental health care facilities tables 2017-18', Table FAC.12 <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-mental-health-care-facilities> [accessed 2 June 2020]. Of this total figure, there are 915 acute and non-acute beds for the general adult population (2017/2018): AIHW, 'Specialised mental health care facilities tables 2017-18', Table FAC.14 <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-mental-health-care-facilities> [accessed 2 June 2020]. This figure differs from the figure provided at p. 48 of the TAPI Submission as the latter was extracted from 2016/2017 AIHW data.

[141] See TAPI Submission, p. 40. While the TAPI Submission relied on earlier population data, using the most recent data, the calculation used to arrive at this figure is as follows: There are almost 4.1 million Victorians aged between 18-64 (ABS, '3101.0 - Australian Demographic Statistics, Jun 2019, Data Cubes: Population by Age and Sex Tables', Table 7, Estimated resident population by age and sex at 30 Jun 2018', <https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3101.0Jun%202019?OpenDocument> [accessed 2 July 2020] at Column C. This age range represents approximately 65% of the total Victorian population (6.5 million). If we assume a 0.7% prevalence of schizophrenia in the population, then 28,700 Victorians in the general adult range have schizophrenia. It is generally accepted that 30% of patients with schizophrenia have treatment-resistant schizophrenia, which then means that 8,610 Victorians have treatment resistant schizophrenia. If we accept that clozapine is initiated in this group with a 50% response rate (see for example Porcelli S, Balzarro B, and Serretti A, 'Clozapine resistance: augmentation strategies' *European Neuropsychopharmacology*, 22.3 (2012), 165-182. doi:10.1016/j.euroneuro.2011.08.005), then 4,300 Victorian are not responsive to clozapine. This 4,300 (rounded to 4,000) therefore represents the

and who have complex multi-agency needs. They may be cycling in and out of homelessness and/or the prison system. They have a high need for the available beds,[142] but the 1,424 beds are not just for this cohort, but are also for people who may not have chronic mental illnesses but are suicidal or otherwise in acute situations of distress. In fact, nearly 60% of overnight separations in public specialist psychiatric facilities in Australia are for patients who do not have schizophrenia or bipolar mood disorder or related conditions.[143]

125 My TAPI colleagues and I consider there is a significant under-provisioning of acute and non-acute mental health beds in Victoria.

(a) The national average for all beds (acute and non-acute, including public and private, for all age groups) is 40.6 beds per 100,000 in 2017/18.[144] Therefore Victoria is 14% below this national average with 35 beds per 100,000 (public and private) for all age groups.[145]

(b) Looking only at public sector psychiatric care beds for all age groups, Victoria had only 22.3 beds per 100,000 (2017-18), which is 21% below the Australian average of 27.9 public sector beds per 100,000 for all age groups.[146]

126 Acknowledging that the Royal Commission's interim report recommends a further 135 additional acute inpatient public mental health beds for Barwon Health and Melbourne Health (in alliance with Western Health and Northern Health), and 35 in the private sector,[147] my TAPI colleagues and I consider there also need to be further beds commissioned for the other adult mental health service catchments in the East and South

number of Victorians between ages 18-64 who have ultra-resistant schizophrenia. This estimate does not include people with other psychotic illnesses who are treatment resistant.

[142] See paragraph 143 and footnote 170 below.

[143] AIHW, 'Overnight admitted mental health related care tables 2017-18',<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/overnight-admitted-mental-health-related-care/non-specialised-admitted-patient-mental-health-care> [accessed 29 June 2020], see Table ON.7.

[144] According to AIHW data, the number of private beds in Australia in 2017-18 was 12.7 per 100,000. AIHW, 'Specialised mental health care facilities tables 2017-18', <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-mental-health-care-facilities> [accessed 2 July 2020], see Table FAC.24. The national average number of public hospital beds is 27.9 beds per 100,000 as set out directly below.

[145] Based on my review of DHHS data, there were 844 private psychiatric hospital beds in Victoria in 2019. For the purposes of this comparison, I have simply assumed that Victoria has 12.7 private beds per 100,000 people (i.e. the same as the national figure referenced in footnote 144 above). See also TAPI Submission, p. 44, Figure 34, where we round up to 13 private beds per 100,000 for Victoria.

[146] AIHW, 'Specialised mental health care facilities tables 2017-18' <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-mental-health-care-facilities> [accessed 2 June 2020] see Table FAC.13.

[147] Interim report, p. 417. The extra 135 beds in the public sector increases maximum general adult acute beds from 779 beds in 2017/18 to 914 beds which represents a 15% increase (19.4 beds per 100,000 to 22.9 beds per 100,000. This still represents a 6% shortfall relative to national average for general adult acute beds (24.4 beds per 100,000).

East. In terms of forensic care, there is also a gross deficiency of beds at the Thomas Embling Hospital. We need more high security and medium security beds.[148]

127 My TAPI colleagues and I recommend an "observed outcomes approach" to calculating minimum and optimal psychiatric bed requirements.[149] On that basis, we have recommended a minimum number of 45 adult inpatient beds (plus six forensic beds) per 100,000 people, amounting to a total of 51 public psychiatric beds per 100,000 people. Our recommended increases in general adult acute and non-acute psychiatric beds are targeted at bringing Victoria back up over the critical threshold of 50 beds per 100,000. This bed-based care needs to be appropriately coupled and integrated with community-based treatment and care.[150]

128 The reasoning, assumptions, literature and evidence-base underlying the TAPI consortium's recommendations are set out in our submissions to the Royal Commission and the Productivity Commission.[151] In particular, we draw on the research and recommendations of the Canadian Psychiatric Association, the Treatment Advocacy Centre in the United States and the Sainsbury Centre for Mental Health in the UK, as well as the medians for the OECD and the WHO.[152]

129 Some people argue that we should model our mental health system on the Trieste model of very low bed numbers. I consider this would be a very significant mistake. If Victoria replicated the low Italian bed numbers (of nine beds per 100,000 people) we would have fewer than a third of the number of mental health beds than we do at present. A recent paper describes an increased rate of suicide in Italy following and possibly partly as a result of radical reforms in Italian mental health policy.[153] The complexities of the mental health system, and the significant demographic, social and policy differences between Victoria and Trieste are some of the key factors that weigh against the applicability of the Trieste model as a best practice exemplar for the Victorian context.

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[148] TAPI's views about increasing adult forensic beds are detailed in section 4.6 of the TAPI Submission.
[149] TAPI Submission, Section 4.3.2 (from p. 43) and the references cited therein, particularly S Allison et al, 'When Should Governments Increase the Supply of Psychiatric Beds?' *Molecular Psychiatry*, 23 (2018), 796-800, <https://www.nature.com/articles/mp2017139> [accessed 3 July 2020].
[150] Expressed differently, a well-functioning mental health systems operates in the top right hand corner of the diagram which appears on page 50 of the VAGO report on Mental Health Access (Figure 3I: Comparison of states and territories on per capita utilisation of mental health beds and community contacts), Victorian Auditor-General's Office, 'Access to Mental Health Services', March 2019, <https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf> [accessed 25 May 2020].
[151] See Section 4.3.2, p. 42 of the TAPI Submission. See also the submissions of the Consortium of Australian Psychiatrists and Psychologists to the Productivity Commission Inquiry, referenced at footnote 6 above.
[152] Ibid and see also TAPI Submission, pp. 105-113. See further at paragraph 130 below regarding OECD medians.
[153] Caterina Ronchetti et al, 'The quantification of the psychiatric revolution: a quasi-natural experiment of the suicide impact of the Basaglia Law', *European Journal of Public Health*, 30 (2020), 521-525. I am a co-author of a forthcoming paper which scrutinises whether the Trieste model works outside Trieste; the manuscript has been submitted to a journal and is in the process of being reviewed.

130 In relation to the use of OECD medians for per capita bed numbers as comparators to bed numbers in Victoria, in circumstances where numerous OECD countries have not deinstitutionalised, I note that:

(a) the Victorian public mental health system has – with the exception of the Thomas Embling Hospital – completely dehospitalised (by which I mean, no other stand-alone psychiatric hospitals have been retained), whereas many OECD countries have not done so; and

(b) some people may argue that Victoria has been 'progressive and constructive' by almost completely dehospitalising, whereas the countries which have not done so, have been reactionary. In my view, it is important to question what is progressive and constructive about a mental health system which has resulted in the community neglect of people with severe mental illness, and their over-representation in gaols or in sub-standard housing or living on the streets, with brief, crisis-focussed revolving door hospitalisations, little access to psychological therapies and premature mortality.

General adult beds

131 If we look separately at acute and non-acute beds (for general adults) for 2017-18, with a total of 915 beds, Victoria is 20% below the national average for acute beds (19.4 versus 24.4 beds per 100,000 people) with 779 acute beds, and more than 55% below the national average of general adult non-acute beds (3.4 versus 7.6 beds per 100,000 people)[154] with 136 non-acute beds.

a) General adult acute beds[155]

132 An increase of 170 beds (including the additional 35 beds in the private sector for public sector patients[156]) as a result of the eventual implementation of the recommendation in the Royal Commission's Interim Report would represent a 22%% increase for public sector general adult acute beds. It would bring the total number of public sector general adult acute beds in Victoria to 949. This equates to 23.6 general adult acute beds per 100,000 people.

133 My colleagues at TAPI and I recommend that we need a level of 30 public general adult acute beds per 100,000 people, which I note is higher than the national average of 24.4

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[154] AIHW, 'Specialised mental health care facilities tables 2017-18', <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-mental-health-care-facilities> [accessed 2 June 2020] see Table FAC.14

[155] The figures in this section are an approximation of general adult acute beds, because the 170 beds recommended in the Interim Report includes youth beds (however the number of youth beds is not specified).

[156] I note that there is no category in the AIHW data of public beds in private hospitals (I consider this is a category that will need to be introduced).

public sector general adult beds per 100,000 in 2017-18 (see paragraph 125 above). This means that, even with the Interim Report's recommended 170 new public sector beds (23.6 beds per 100,000),[157] Victoria will have 6.4 public sector general adult beds per 100,000 people less than our recommended minimum (a 21 % shortfall).

134 To address this deficit, my colleagues at TAPI and I recommend that there need to be approximately 230 additional public sector general adult acute beds (on top of the 170 public and sector general adult acute beds recommended by the Royal Commission in its Interim Report).[158].

135 Further, and as set out in the TAPI Submission,[159] my TAPI colleagues and I strongly endorse a much closer inter-connectivity between the public and private mental health sectors but it is important to note that the private hospital beds will only be able to be used for those patients (currently less than 50%[160]) who are admitted on a non-compulsory basis. In addition, public mental health facilities have more experience in caring for voluntary patients who pose a serious threat of self- harm or harm to others, or are aggressive or behaviourally disinhibited.

b) <u>General adult non-acute beds, extended care and the need for specialist mental health centres</u>

136 According to Australian Institute of Health and Welfare (**AIHW**) data, Victoria had 136 general adult non-acute beds in 2017/18, which represents 3.4 beds per 100,000 people.[161] There is no recommendation in the Royal Commission's Interim Report for the number of general adult non-acute beds to be increased.

137 My colleagues at TAPI and I recommend that the number of general adult non-acute beds be increased to 15 beds per 100,000, meaning that we currently need an extra 464 public sector general adult non-acute beds.[162]

138 In my view, the Victorian mental health framework released in 1994 did not properly take into account the extended care needs of people with long term mental illness.[163] The reforms of the early 1990s are in my view one of the reasons for the under-provisioning

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[157] Because the projected bed calculations were based on the population of Victoria in 2017 (as the denominator), and the total population has increased by at least 4.5% since 2017, this figure is an overestimate (i.e. the number of beds per capita will be lower than 22.8 beds per 100,000 people).
[158] The TAPI Submission states that there should be a total of 1,179 general adult acute beds for 2016/17. Factoring in population growth, this would be 1,250 such beds for 2020, meaning there is a shortfall of 336 beds for 2020 (1,250 minus 779 minus 135).
[159] At pp. 71-72.
[160] See paragraph 250 and footnote 298 below.
[161] AIHW, 'Specialised mental health care facilities tables 2017-18', <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-mental-health-care-facilities> [accessed 3 June 2020], see Table FAC.14 .
[162] TAPI Submission, p. 48.
[163] Psychiatric Services Division, Dept. of Victorian Government Dept. of Health and Community Services, 'Victoria's mental health services: the framework for service delivery', 1994.

of long-term non-acute beds in this State.[164] This remains a deficiency in Victoria's current mental health system.

139 As discussed further below from paragraph 144, a significant minority of people who currently need extended care have not been adequately served by the mental health and other (e.g. NGO or public housing) systems and are often living in very sub-standard accommodation, or are homeless, or are in prison. In particular, the level of care currently provided in non-acute non-hospital settings is not adequate for people with complex multi-agency needs and those who may lack insight into their illness or are on community treatment orders and resistant to treatment. Further, my understanding is that, because of the severity of illness of people on hospital wards, and the frequency of disruptive behaviours of forensic presentations, the expectation is that SECUs will provide therapeutic and rehabilitative care. However, in my view, some of the people who are currently in SECUs now would be better suited to other environments.[165]

140 As compared with SECUs, general non-acute mental health beds – preferably located in Specialist Mental Health Rehabilitation Centres – would be much more focused on helping improve the quality of life and, preferably, the rehabilitation of people who have enduring and severe psychiatric illnesses. SECUs have become increasingly quasi-forensic facilities and in my view are not able to fulfil this role satisfactorily. As the Victorian Mental Health Tribunal has submitted to the Royal Commission (which I agree with):

> "SECUs were not designed to be actual or quasi permanent residences, they are forced into fulfilling this role. … There is a need for long-term residential services incorporating intensive models of support and care but SECU is not the answer. … As sub-acute services SECU's are intended to be a more settled environment, within which individuals with enduring illness are provided with longitudinal treatment and support, with the aim of achieving better and prolonged reduction of highly debilitating symptoms, and regaining or developing skills for community living. This objective appears to sit uncomfortably with an increase over time in the proportion of SECU patients who for a variety of reasons, can present with aggressive behaviours. Responding to and managing for those behaviours fundamentally alters the milieu of a SECU, arguably requiring it to provide a service it was not intended to provide, at the expense of providing the environment and support for which it was established."[166]

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[164] See the brief overview of de-hospitalisation and reduction in bed-based care, from paragraph 96 above.
[165] See further the discussion from paragraph 123 about quantifying the number of mental health beds needed in Victoria.
[166] Formal submission from the Victorian Mental Health Tribunal to the Royal Commission into the Victorian Mental Health System, June 2019, (SUB.1000.0001.0979) <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/9015/6711/5782/Victorian_Mental_Health_Tribunal.pdf> [accessed 16 June 2020] at section 3.1, pp. 24-25.

141 In my view, mental health wards in general hospitals are also inappropriate places for accommodating people with severe mental illness who require longer-term care, but who are unsuitable to be discharged from the wards. This group comprises a minority sub-set of people with schizophrenia (and related disorders) who, combined, account for approximately 60% of occupied bed days in public general adult wards, as follows:

(a) approximately 40% of overnight separations in public specialist psychiatric facilities in Australia are for patients with schizophrenia and related disorders, plus bipolar disorder and related disorders;[167]

(b) OECD data indicate that the average length of stay of this group in Australian hospitals is at least double that of those with depression or anxiety diagnoses.[168]

(c) this then means that approximately 60% of occupied bed days in general adult wards are attributable to this cohort.[169]

142 People needing longer-term care should be able to receive this kind of care in the community or as outpatients or in Specialist Mental Health Rehabilitation Centres. We need to do more work to develop more appropriate offerings of longer-term specialised accommodation (i.e. extended care) and long-term rehabilitation facilities.

143 The need for specialised mental health facilities is highlighted by a recently published paper in which my colleagues and I showed that a small cohort of severely and chronically ill patients utilised a very large number of bed-days in the mental health care system in Western Australia.[170] In that State, which has a population 40% that of Victoria,[171] between 2013 and 2017, 1,500 adult patients had inpatient admissions in acute wards lasting more than 100 days with 126 staying longer than 12 months.[172] These patients

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[167] AIHW, 'Overnight admitted mental health related care tables 2017-18', <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/overnight-admitted-mental-health-related-care/non-specialised-admitted-patient-mental-health-care> [accessed 29 June 2020], see Table ON.7. See also paragraph 124, footnote 143 above.

[168] Using the latest data (2017) on hospital average length of stay for Australia from OECD.Stat, <https://stats.oecd.org/> [accessed 2 July 2020], the average length of stay for the diagnostic categories "Mood (affective) disorders" and "Other mental and behavioural disorders" are 15.9 and 10.4 days, respectively (to give a combined average of 13.15 days (=(15.9+10.4)/2), which is almost half the average length of stay for schizophrenia and related disorders (25.4 days). I note that all of these hospital average length figures are for Australia as a whole and are considerably longer than the average length of stay from Victorian data of 9.6 days for all patients (see Victorian Auditor General's Office, 'Access to Mental Health Services', March 2019 <https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf> [accessed 2 July 2020] at pp. 11 and 45), however to my knowledge there is no data source that addresses this issue precisely for Victoria

[169] To calculate the number of bed days, one multiplies the number of presentations x length of stay. Total bed days = (40% (n) x 2 [sz] + 60% (n) [non-sz]). Where, say n = 100 patients = 140 bed days. Sz patients = 80 of those bed days. 80/140 = 57%, rounded to approximately 60%.

[170] Allison, S., Bastiampillai, T., Looi, J.C. and Copolov, D., 'Pareto's law of the vital few: Patient requirements for hospital based non-acute care', *Australian & New Zealand Journal of Psychiatry*, 54.2 (2020), 205-206.

[171] Australian Bureau of Statistics, '3101.0 - Australian Demographic Statistics, Jun 2019', Table 4, Estimated Resident Population, States and Territories (Number). As at June 2019, the estimated population of Victoria was 6,594,804 and the estimated population of Western Australia was 2,621,680.

[172] Ibid. at 205, where my colleagues and I state: "In a recent report to Parliament, the Western Australian Auditor General (https://audit.wa.gov.au/) identified 1,500 adult mental health patients who had hospital inpatient stays of 100 days or more during 2013/2017. Their diagnostic profiles were not reported, but

would be more appropriately cared for in a specialised, long term mental health facility with a focus on rehabilitation. Patients such as these include those who we refer to in the TAPI Submission as having ultra-treatment resistant psychotic illnesses (as described in more detail in paragraph 124 above) and those whose care was, in my view, under-provisioned for by the Victorian Mental Health Framework (see paragraph 100 above).

Particular needs of people who are imprisoned

144 Another reason for significantly expanding extended care mental health facilities is that a number of people in prison who have serious psychiatric illness should be cared for in specialist mental health rehabilitation centres rather than being incarcerated within the prison system.

145 Victoria's current prison population is more than 8,100.[173] The estimated prevalence of psychosis in New South Wales prisons is 7%, which is ten times greater than the estimated prevalence of psychosis in the Australian population.[174] Even if the prevalence of psychosis in Victorian prisons is lower than that in New South Wales prisons and is instead closer to the estimate from Fazel and colleagues (4%), that would mean that more than 300 Victorian prisoners have a psychotic disorder.[175] I consider that a number of those 300 prisoners, perhaps more than 100, would be suitable for transfer to a specialist mental health treatment and rehabilitation centre. My colleagues in the TAPI consortium and I have included a significant section in the TAPI Submission about the major shortfall in the provision of forensic mental health care in Victoria.[176]

Particular needs of people who are homeless

146 The AIHW highlights that on Census night in 2016, around 8,200 people were sleeping rough in Australia.[177] According to *Victoria's homelessness and rough sleeping action plan*:

> "In Victoria on any given night there are approximately 1,100 people sleeping rough, making up around five per cent of the state's homeless population. Rough

probably included adults with treatment resistant mental illness, and older adults with cognitive impairment and aggression. Of these, 126 patients stayed for 12 months or more in acute bed, reducing available capacity by 83,000 inpatient days, at an estimated cost of AUD$115 million: acute beds are the most expensive option for non-acute care."

[173] Corrections, Prisons & Parole, 'Corrections statistics: quick reference' <https://www.corrections.vic.gov.au/prisons/corrections-statistics-quick-reference> [accessed 13 June 2020].

[174] Tony Butler et al, 'Mental disorders in Australian prisoners: a comparison we with a community sample', *Australian and New Zealand Journal of Psychiatry*, 40.3 (2006), 272-276. See in particular Table 2.

[175] Seena Fazel et al, 'Mental health of prisoners: prevalence, adverse outcomes, and interventions' *The Lancet Psychiatry*, 3.9 (2016), 871-881.

[176] TAPI Submission, section 4.6.

[177] AIHW, 'Sleeping rough: a profile of Specialist Homelessness Services clients', 2018, <https://www.aihw.gov.au/getmedia/96b4d8ce-d82c-4149-92aa-2784698795ba/aihw-hou-297.pdf.aspx?inline=true> [accessed 1 July 2020] at p. 1.

sleeping is an unsafe situation for anyone to be in – whether that involves sleeping in a car, on the street, in a park, or in a derelict building. It has many complexities that multiply over time."[178]

147 While in 2016 it was found that 1,100 people were sleeping rough on Census night, a recent research report prepared for the Parliamentary Inquiry into Homelessness by Professors Chamberlain and Johnson found evidence of undercounting and indicated that the number of rough sleepers was probably closer to around 2,200.[179] It is axiomatic that, over the course of a year, the numbers of Victorians sleeping rough are much higher than this because Census night just provides a cross-sectional count on a given day.

148 Research by the AIHW found that nearly 40% of adult rough sleepers reported ever having a mental health diagnosis and 26% of adult clients of specialist homeless services (**SHS**s) have a formal mental health diagnosis.[180] Around 112,900 people were assisted by SHSs in Victoria in 2018-19; [181] Victoria had the largest number of clients who accessed SHSs of all Australian states and territories.[182] If 26% of adult SHS clients (excluding rough sleepers) have a formal mental health diagnosis, this equates to 29,000 Victorian with a mental illness receiving SHSs.

149 Consideration of our (TAPI's) suggestion for 600 non-acute psychiatric beds in specialist rehabilitation centres must take into account the approximately 400-850 Victorians with mental illness sleeping rough on any given night.[183]

150 Although a short-term solution has been found to assist some homeless people during the COVID-19 crisis,[184] much more needs to be done to help this group of people in the

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[178] DHHS, 'Victoria's homelessness and rough sleeping action plan', January 2018, <https://www.dhhs.vic.gov.au/sites/default/files/documents/201802/Rough%20Sleeping%20Action%20Plan_20180207.pdf> at p. 4 (Minister's foreword).

[179] Chris Chamberlain and Guy Johnson, 'How Many Homeless People in Victoria? A research report prepared for the parliamentary inquiry into homelessness in Victoria', January 2020, <https://www.parliament.vic.gov.au/component/rsform/submission-view-file/dc5dc6a4dabe65e8588d9a09fb1f1ae4/ec2deaba9ff1ddca9e265cab4f5fb039?Itemid=527> [accessed 1 July 2020] at pp. 1 and 11.

[180] AIHW, '*Sleeping rough: a profile of Specialist Homelessness Services clients*', 2018, <https://www.aihw.gov.au/getmedia/96b4d8ce-d82c-4149-92aa-2784698795ba/aihw-hou-297.pdf.aspx?inline=true> [accessed 1 July 2020] at p. 3. See also the information at p. 8.

[181] AIHW, 'Specialist homelessness services 2018–19: Victoria' <https://www.aihw.gov.au/getmedia/29e84edc-c552-4f5d-b11a-1c14011ddca8/VIC_factsheet-20-05-2020.pdf.aspx> [accessed 1 July 2020].

[182] AIHW, 'Specialist Homelessness Services annual report 2018-19' <https://www.aihw.gov.au/reports/homelessness-services/shs-annual-report-18-19/contents/summary> [accessed 17 June 2020].

[183] This is based on a calculation of 39% of 1,100 and 2,200 people.

[184] This assistance has been focused on helping homelessness agencies with extra resources, contributing to private rental brokerage for people at risk of homelessness, and establishing pop up accommodation for homeless people requiring isolation. Premier of Victoria, 'More Homelessness And Public Housing Support In COVID-19 Fight',18 March 2020, <https://www.premier.vic.gov.au/more-homelessness-and-public-housing-support-in-covid-19-fight/> [accessed 1 June 2020]; Jewel Topsfield, 'How the shock of COVID-19 could end street homelessness in Victoria', *The Age*, 13 June 2020, <https://www.theage.com.au/national/victoria/how-the-shock-of-covid-19-could-end-street-homelessness-in-victoria-20200612-p551vk.html> [accessed 17 June 2020], referring to new social housing funding.

longer term. This includes providing appropriate care and accommodation for homeless people with severe psychiatric illness.

151 Consideration should also be given to the way that Finland has tackled homelessness. In particular, the adoption of the Housing First model in Finland shows that it is possible to not only create short term solutions (as with the current response to the COVID-19 pandemic), but also to take a radical and effective approach to improving the plight of the chronically homeless in the long term.[185] In my view, we are too inward-looking when it comes to dealing with problems such as serious mental illness and homelessness – we need to be much more aware of, and take into account, the solutions that have worked in other countries, in this case the reduction of homelessness in Finland.[186] But in addition to accommodation solutions, people with severe and enduring psychotic illnesses may require longer term hospitalisation and rehabilitation.

Summary of recommendations for total number of general adult beds

152 For the reasons set out above, and based on considerations outlined in the TAPI Submission, it is my view that:

(a) after the creation of the 170 additional youth and adult acute mental health beds (135 in the public sector and 35 in the private sector for public patients) recommended in the Royal Commission's Interim Report, at least an additional 694 public sector general adult acute and non-acute beds are needed over the short to medium term, to be adjusted to account for population numbers over the years.[187] This would represent at least a 64% increase in adult psychiatric beds over the current bed numbers plus the new ones being established as a result of the Royal Commission's Interim Report (or a 75% increase if the 170 additional beds are not included).[188] As noted above, this suggested increase does not include the need to at least double the number of forensic beds from 152 (3 per

[185] Housing First Europe Hub, 'Finland', <https://housingfirsteurope.eu/countries/finland/> [accessed 8 June 2020].
[186] See for example, Alex Gray ,'Here's how Finland solved its homelessness problem' *World Economic Forum,* 13 February 2018, <https://www.weforum.org/agenda/2018/02/how-finland-solved-homelessness/> [accessed 8 June 2020] and Jon Henley, ''It's a miracle': Helsinki's radical solution to homelessness', *The Guardian*, 3 June 2019.
[187] The recommendation of 694 additional beds comprises 230 public sector general adult acute beds and 464 public sector general adult non-acute beds. In my view, there should be an increase of up to 725 additional public sector general adult acute and non-acute beds.
[188] The recommended increase of 694 beds equates to approximately 75% of the current number of beds (915). I note that this is less than the view expressed by Dr Ruth Vine that perhaps a doubling of beds should be implemented. See witness statement of Dr Vine dated 29 April 2020 <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/6915/9114/2723/Vine_Ruth.pdf> [accessed 28 June 2020] where Dr Vine states, at paragraph [66]: "To reduce the rates of compulsory treatment use, there needs to be many more beds – maybe double – in the mental health system, greater community mental health service capacity, and probably changes to the primary care sector as well."

100,000 of the population) to more than 300 (more than 6 per 100,000 of the population);[189] and

(b) in order to prevent the circumstances arising in which future Royal Commissions into Victoria's Mental Health System need to be called because the system is far from being 'fit for purpose', the current Royal Commission should specify in some detail and mandate the minimum level of provision of care for inpatient, community and outpatient care. These minimum levels should be subject to detailed review every five years, based on the outcomes suggested at paragraph 171 below, and at page 47 of the TAPI Submission.

153 These recommendations take into account the need to further increase general adult acute beds, and to look after the needs of patients who require non-acute care (many of whom are inappropriately living in marginal housing or are being admitted in revolving door fashion to acute mental health wards and some of who are in gaol).

The Role of the Victorian Collaborative Centre for Mental Health and Wellbeing in mental health care and research – and the need for more than one

154 The Royal Commission's interim report recommends that a single Collaborative Centre for Mental Health and Wellbeing should be set up for the whole of Victoria.[190] As I understand it, the logic is that even though the Collaborative Centre will only service a particular area of Melbourne, it is intended to influence practice throughout the State. The establishment of such a Centre is an excellent development, and has received widespread endorsement by members of the TAPI consortium and beyond.

155 At present, we have distributed the psychiatric wards throughout many hospitals and there are no centres of excellence for mental health. I consider that establishing Specialist Mental Health Centres is a fundamental part of reforming the mental health system.

156 However, in my view adult psychiatry is in need of more than one nidus of concentration of expertise and excellence; at least two such centres should be set up in Victoria, even if the second only follows the first after a number of years. The main reasons for this are:

(a) *first,* having only one collaborative centre is not sufficient to meet the needs of a State as big as Victoria, with a current population of 6.65 million people[191] and an expected population of 10.1 million people by 2051.[192] By way of comparison,

[189] See section 4.6 of the TAPI Submission.
[190] Chapter 13.
[191] As at 31 December 2019. Australian Bureau of Statistics, '3101.0 - Australian Demographic Statistics, Dec 2019' (States and territories) <https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3101.0Main%20Features3Dec%202019?opendocument&tabname=Summary&prodno=3101.0&issue=Dec%202019&num=&view=> [accessed 4 July 2020].
[192] This projection of population growth is drawn from: Department of Environment, Land, Water and Planning, '*Victoria in Future 2016: Population and household projections to 2051*' (2016), available at

Victoria currently has three specialist maternity (and neonate or children's) hospitals,[193] two specialist children's hospitals[194] and two specialist cancer hospitals;[195] and

(b) *second,* if we want to fully harness the strength of *both* of Victoria's major, world-class, research-intensive universities in the area of psychiatry, we should have at least two specialist mental health centres.[196] In my personal view, whilst I understand that the Collaborative Centre will primarily be linked to a health service rather than a university, if there is only one Centre and it is set up close to one of the major universities or one of their associated hospitals, the practical likelihood of harnessing the research knowledge, and obtaining genuine buy-in and deep engagement from the State's other universities would be limited.

157 Indeed, over the long term my TAPI colleagues and I consider that the Victorian Government should establish:

(a) "three to six specialist university-affiliated Mental Health Acute-Care Centres... over the next 15 years, aiming for the first two within five years"; and

(b) "three to six specialist university-affiliated Mental Health Rehabilitation Centres... over the next 15 years, aiming for the first three within five years". [197]

158 These Specialist Centres should be located close to general hospitals. They should focus on acute care and rehabilitation and should provide coordinated inpatient, day patient, outpatient and community outreach services.

The National Mental Health Service Planning Framework (NMHSPF) perspective on the provision of non-acute beds in the public mental health sector

159 The NMHSPF arose from the Fourth National Mental Health Plan[198] and began in 2011. In 2016 responsibility for reviewing and refining the NMHSPF was transferred to the University of Queensland under the leadership of Professor Harvey Whiteford. There

<https://www.planning.vic.gov.au/__data/assets/pdf_file/0014/14036/Victoria-in-Future-2016-FINAL-web.pdf> [accessed 6 July 2019].

[193] The RWH and Mercy Hospital for Women cater to women and babies, and the newly opened Joan Kirner Women's and Children's Hospital caters to women and children. See TAPI Submission, pp 58-59.

[194] Being the Royal Children's Hospital and the Monash Children's Hospital within Monash Health.

[195] Being the Peter MacCallum Cancer Centre and the Olivia Newton-John Cancer Wellness and Research Centre within the Austin Hospital.

[196] The Victorian universities with the largest Medical faculties are Monash University and the University of Melbourne, which are associated with the Alfred Hospital and Royal Melbourne Hospital, respectively.

[197] TAPI Submission, Recommendations 11 and 12. See Section 5.1, pp. 57-62.

[198] Australian Government, Department of Health, 'Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014' last updated 19 August 2009, <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-f-plan09> [accessed 3 July 2020].

have been some technical modifications to the NMHSPF since its introduction, including for rural and regional areas and Indigenous populations.

160 One of the great strengths of the NMHSPF is that it is underpinned by excellent epidemiology. The NMHSPF's epidemiological modelling has been used by the National Mental Health Commission and by the Royal Commission in its interim report.

161 The NMHSPF is extremely detailed, which is commendable. However, I understand it is difficult to understand what the bases are for many of the assumptions and recommendations made within the NMHSPF, in other words, what lies 'underneath the bonnet?' For example, the NMHSPF recognises that there has been a significant decline in the number of public sector non-acute beds on a per capita basis – and has come to the conclusion that there is a 60% shortfall in the number of such beds. More specifically the NMHSPF has reported that there are 3,436 beds whereas there should be a target of 5,852 Australia-wide. [199]

162 My TAPI colleagues and I strongly agree with the observation that there is a major shortfall in the availability of general non-acute beds.[200] However, whereas the NMHSPF recommends a 66/33% ratio of community residential to hospital non-acute beds for all age-groups,[201] my TAPI colleagues and I are of the view that that the majority of these non-acute beds should be hospital-based rather than being residential beds in the community, for reasons that relate to:

(a) optimising levels of mental health professional availability to patients;

(b) ensuring the ability of facilities to manage patients with comorbidities and significant behavioural problems;

(c) maximising rehabilitation opportunities and to bring psychiatric rehabilitation 'in from the cold'; and

(d) starting the important journey of Victoria being able to undertake significant and practically useful research psychiatric rehabilitation

As noted above at paragraph 137, the TAPI Submission recommends at least 15 public sector hospital general adult non-acute beds per 100,000 of the population, This is nearly five times greater than the current provision in Victoria of 3.4 beds per 100,000 of the population. These beds should be located in Specialist Mental Health Rehabilitation

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[199] Productivity Commission into Mental Health, 'Draft Report, Volume 1', October 2019, <https://www.pc.gov.au/inquiries/completed/mental-health/draft/mental-health-draft-volume1.pdf> [accessed 17 June 2020] at pp. 286-287 and see also at pp. 311-312.

[200] As detailed above from paragraph 123 and particularly at paragraph 137.

[201] Productivity Commission into Mental Health, 'Draft Report, Volume 1', October 2019, <https://www.pc.gov.au/inquiries/completed/mental-health/draft/mental-health-draft-volume1.pdf> [accessed 17 June 2020] at p. 287.

Centres, for reasons that are explained on page 62 of the TAPI Submission and summarised above.

163 The service mix recommended in the NMHSPF needs to be tested. There should at least be transparency and an open debate about the levels of care and service requirements. In addition, after an appropriate level of open discussion, guidance should be given to emphasise that the levels of care are not just an aspiration. The NMHSPF was established in order to set detailed plans and goals. While goals and aspirations are important, I consider that what we in fact need are *mandated* minimum standards of care – including minimum bed numbers per capita – and outcome measurements.[202]

164 It is my view that by eschewing the introduction of such minimum standards, the "masterplan" for Victoria's mental health services[203] – which has many highly recommendable elements – contributed to significant under-provisioning of services, especially inpatient services, that has resulted in circumstances which have led to the calling of the current Royal Commission.

Minimum standards of care – A best practice example from Germany

165 From 1990 onwards the German federal government has required that all patients who are admitted to hospital receive at least a minimum set amount of time per week of face to face contact with a range of mental health professionals, including doctors, nurses, occupational therapists, physiotherapists and social workers, with contact with each category of mental health professional being specified. The minimum mandated amount of time per patient depends on factors including the patient's age ranges and their diagnoses.

166 The German framework is facilitated through two ordinances: the Psych-PV (which groups inpatients by treatment areas and types of treatment) and the Psych-VVG (which provides for care and remuneration for inpatient psychiatric and psychosocial services). In this way, the German government essentially mandates the delivery of a certain quanta of care for each person admitted to hospital.[204]In my view the mandating of specific quanta of mental health care and the 'in step' enhancement of both inpatient and community care[205] were important factors in contributing to the fact that The Economist's

[202] See the discussion from paragraph 127 above regarding outcome measurements.
[203] Psychiatric Services Division, Dept. of Victorian Government Dept. of Health and Community Services, 'Victoria's mental health services: the framework for service delivery';, 1994. See in particular the discussion of "The 'Planning Norms' Approach to Resource Allocation' at p. 51.
[204] See further Heinrich Kunze et al, 'Psychiatric Services in Germany' *Psychiatric Bulletin*, 28 (2014), 218-221.
[205] See the discussion at paragraphs 102 to 105 above.

2014 review on mental health and integration in Europe, found that Germany was the leading provider of mental health services in Europe.[206]

167 The German system of minimum standards supports the view that we should not be focusing on numbers of mental health beds per se; rather, we should be focusing on the standard and scale of care that is provided to patients. These standards should apply equally to care provided to inpatients in hospitals, outpatients and to patients in the community.

Performance monitoring

Accountability mechanisms to better enable performance oversight

The need for comprehensive outcome measurement

168 The suite of KPIs that currently exist for mental health services are inadequate in that they do not include a sufficient range of quality outcomes. While current outcome measures, such as reduced restraints, reduced seclusion and reduced readmission rates are all very important, I consider that the most important outcome measures for anyone with any mental illness are that they:

(a) have the best quality of life possible, which optimises their capacity to contribute to society and to enjoy close social connectedness;

(b) are in an integrated system where they go from hospital into the community knowing that there is security of accommodation joined up with various services, including employment, legal, and social services and the provision of educational opportunities.

169 At present, psychiatric patients are given Health of the Nation Outcome Scales (**HoNOS**) scores when they are admitted to hospital and then when they are discharged. Data published by the AIHW show that, since the data were first collected in 2007-8, between approximately 73-76% of inpatient episodes of mental health care have recorded significant improvements in patient HoNOS scores, which is an important indicator of the value of inpatient care.[207]

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[206] The Economist Intelligence Unit, 'Mental health and integration. Provision for supporting people with mental illness: a comparison of 30 European countries', 2014. The report is summarised here: <http://www.eiu.com/industry/article/662372850/eiu-report-mental-health-and-integration/2014-10-10> [accessed 3 July 2020].

[207] Note that the data collected on inpatient episodes of mental health care exclude brief episodes of mental health care where a consumer is admitted for a period of three days or less. The full set of data on mental health key performance indicators is published by the AIHW in its web report, 'Mental Health Services in Australia'. The data are available at AIHW, 'Mental health services in Australia' <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-indicators/key-performance-indicators-for-australian-public-mental-health-services> [accessed 4 June 2020].

170 However, in addition to rudimentary tools like HoNOS scores, we also need more holistic and comprehensive outcome measures; we need to be able to empirically map what is happening in our patients' lives across many domains, including employment and housing. Many aspects of, and changes to the mental health system have been ideologically driven; instead, they need to be more data driven. We need to shift towards a more robust, empirically supported approach to outcome measurement. Any major changes to the provision of care need to build in appropriate outcome measures. The purpose of these outcome measures is to inform the quality of care and the method of service delivery, both in hospitals and in the community.

A suggested framework

171 My colleagues Richard O'Reilly, Stephen Allison and Tarun Bastiampillai conducted a literature review of hospital Key Performance Indicators (**KPIs**) and population outcomes, which revealed that when the following 16 KPIs/outcomes are used in combination, they are "powerful determinants of the adequacy or otherwise of mental health bed numbers."[208]

Hospital KPIs	**Population Outcomes**
Out of area placements	Rates of homeless amongst people with severe mental illness (**SMI**)
Boarding in emergency rooms	Rates of people with SMI in homeless shelters
Involuntary admission	Rates of all-cause mortality
Occupancy rates in psychiatric units	Rates of suicide
Level of acuity in inpatient wards	Rates of crime committed by people with SMI
Discharge to homelessness	Rates of incarceration amongst people with SMI
Readmission rates	Rates of people with SMI in gaols
	Burden on carers

Table adapted from Figure 39 in the TAPI Submission, citing O'Reilly et al (2019)[209]

172 Each of these KPIs and outcomes should be captured as part of any reforms to the Victorian mental health system. As we state in the TAPI Submission:

[208] TAPI Submission, p. 47, Figure 39, citing Richard O'Reilly, Stephen Allison and Tarun Bastiampillai, 'Observed Outcomes: An Approach to Calculate the Optimum Number of Psychiatric Beds', *Administration and Policy in Mental Health and Mental Health Services Research*, 46.4 (2019), 507–517, <https://pubmed.ncbi.nlm.nih.gov/30778781/> [accessed 4 July 2020].
[209] Ibid.

> "It is important to capture these KPIs as they speak directly to the burden of disease felt by patients, their families, and the community: including long waits for care, sub-optimal care, suicide, crime, incarceration, homelessness, and carer burden. We submit that if a sufficient number of beds were provided there would be significant health, social, and economic advantages both to patients and the broader community – including on these broad KPI outcomes described above." (at page 47)

173 In other words, we can take it as a given that the purpose of reforming the mental health system is to improve the lives of people with mental illness and their families and the society as a whole and that any changes to the system will not be relevant if they do not make a measurable difference in terms of lowering the indices listed in the table above and also in reducing unemployment in people with mental illnesses.

174 The outcome measurement framework described above should be supported by high-quality clinical information systems and infrastructure, including:

(a) a regular census of serious mental illness;

(b) real-time clinical quality registries; and

(c) electronic Mental Health Records for patients who are served by the public mental health sector.[210]

175 From my perspective as a former largely full-time psychiatric researcher, it is my view that the Royal Commission should recommend to the State Government that it considers major policy changes to mental health system as being an ongoing series of system-wide experiments in which a carefully curated set of outcomes needs to inform either the endorsement and stabilisation of policies or further changes to them. Because there are so many 'moving parts', it will always be difficult to determine which changes have led to which outcomes, and the lag-time before efficacy can be assessed will be in years rather than months. Notwithstanding that, the suite of outcomes recommended by Richard O'Reilly and his colleagues – and perhaps other outcomes – represents a very good basis upon which a 'gestalt' assessment of the mental health system can be made, and upon which policy determinations can and should be made.

The role of clinical registries

176 Mental health can learn much from areas of other medical area in relation to the establishment and use of clinical registries, both nationally and internationally.[211] For

[210] See TAPI Submission, Section 6.2, pp.67-71.
[211] The Australian Commission on Safety and Quality in Health Care provides further information about the important role of clinical quality registries, see: <https://www.safetyandquality.gov.au/our-work/national-arrangements-clinical-quality-registries#role-of-clinical-quality-registries> [accessed 25 May 2020].

example, in Australia, we have clinical registries for issues such as melanoma, prostate cancer and intensive care admissions. An effective clinical registry is highly dependent on electronic medical records.

177 An excellent international example of a clinical registry is the Danish Schizophrenia Registry.[212] The Registry was founded in 2003 and since 2012 it has covered all hospital psychiatric units in Denmark undertaking treatment for patients with schizophrenia. In 2014 more than 14,000 patients were recorded in the Registry. The Registry currently records information on 21 clinical variables including in relation to functional outcomes, medication and, importantly, physical health.

178 A recent article published in the New England Journal of Medicine reports on a study which utilised the Danish Psychiatric Central Research Register to demonstrate the association between mental illnesses and physical illnesses.[213] Denmark has a population of more than 5.9 million people and was able to study almost 700,000 people with mental illness by virtue of the data in the Danish Psychiatric Central Research Register. It would be impossible to contemplate a similar study in Australia of anywhere near that scale, even though we have a population which is more than four times that of Demark,[214] without the appropriate clinical registries.

179 The vital importance of clinical registries and other clinical information systems in mental health is discussed in the TAPI Submission at pages 67 to 72.

Governance

The importance of complementary skills on hospital boards

180 In my view, one of the most important aspects of the governance of health services is to have a board that is comprised of people with a diverse and complementary set of skills and experience. This is a signature characteristic of boards within Victoria's health system, including the specialist public hospital boards with which I have been associated over the last 15 years.

181 For example, as a long-standing (now former) director of the Board for RWH, I did not represent the mental health sector, but I did bring my skills and expertise in areas such as research, mental health, administration and governance to this role. Other members

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[212] See Lone Baandrup et al, 'The Danish schizophrenia registry' *Clinical Epidemiology*, 8 (2016), 691. See also Copenhagen Health Tech Cluster, 'The Danish Schizophrenia Registry', <https://www.danishhealthdata.com/find-health-data/Den-Nationale-Skizofrenidatabase> [accessed 4 July 2020].

[213] Natalie C Mormen et al, 'Association between Mental Disorders and Subsequent Medical Conditions', *New England Journal of Medicine*, 382.18 (2020), ,1721-1731.

[214] According to the ABS, Australia's population as at 31 December 2019 was 25.5 million people. Australian Bureau of Statistics, '3101.0 - Australian Demographic Statistics, Dec 2019' <https://www.abs.gov.au/ausstats/abs@.nsf/mediareleasesbyCatalogue/CA1999BAEAA1A86ACA25765100098A47> [accessed 2 July 2020].

of the board had complementary skills – for example, clinical quality assurance, law, finance, audit and risk analysis and human relations. Other board members come from the 'community at large'.

182 Board members of Victorian public health services are appointed by government – they provide a level of governance, with voices of independent individuals from the Victorian community, that sit between the senior management of hospitals and the DHHS. They are therefore closer to and are able to be more engaged with the hospitals than senior staff within the DHHS. It is my understanding that, with the exception of Forensicare, no public mental health services directly receive the benefits that are associated with having government-appointed boards of directors who come from the general community. My TAPI colleagues and I recommended the establishment of such boards for the management of the governance of Specialist Mental Health Centres.

183 This would be analogous to the way in which, for example, women and neonates are the core focus of the attention of the Board at RWH. As the TAPI Submission states:

> "The Centres should be governed by a Board of Directors with oversight of the Centre management teams and with direct line responsibility for performance of services to the state government… The model has many strengths, including a dedicated independent board to act exclusively on behalf of the population that it serves as in the case of the Royal Women's Hospital and the Peter MacCallum Cancer Centre." (at page 61)

184 Whether or not the Victorian Collaborative Centre for Mental Health or, if established, other centres adopt this suggestion, it is very important in the view of my TAPI colleagues and I that governance arrangements for mental health services located in the current public health services are at least bolstered.

Making mental health a priority for the board

185 Although I have been a Board Director of two public health services/hospitals—and both of these hospitals have mental health services—I have never sat on a Board that runs major and mainstream mental health services. It is my understanding from speaking to senior clinicians at major mental health services that it is sometimes difficult to ensure that enough dedicated time is able to be spent by the Board of Directors of general tertiary hospitals on the governance of mental health within the broad responsibilities of overseeing the running of major health services.[215]

[215] That being said, all public health services must fulfil KPIs relating to mental health as part of their statement of priorities.

186 Regardless of whether the Royal Commission accepts our recommendation to establish a number (i.e. beyond the Victorian Collaborative Centre for Mental Health and Wellbeing) of Specialist Mental Health Centres, my TAPI colleagues and I recommend that each major public health service which runs a major health mental health service should be required to have a Mental Health Committee which reports to and advises the hospital board, in the same manner that each board has Finance, Audit and Risk and Quality and Safety committees reporting to them. I consider that this step would:

(a) help bring mental health issues into greater prominence;

(b) increase board oversight and accountability with respect to the achievement or lack of achievement of the various goals and KPIs relating to mental health;

(c) provide greater connection between mental health and other aspects of a general health service; and

(d) mean that hospital boards (and in turn hospital CEOs and senior management) give more attention to not only the achievement of service goals but also matters such as fundraising and advocacy for mental health.[216]

Other governance reforms

187 My TAPI colleagues and I consider we need to reform the governance of mental health services in Victoria in a root and branch manner. The TAPI Submission sets out in further detail the steps we consider necessary to reshape the governance of mental health in Victoria, including reforms to:

(a) Ministerial portfolios;

(b) Mental Health Branch reporting relationships;

(c) enhance clinical input to the Mental Health Branch; and

(d) enhance the role of Safer Care Victoria in mental health safety and quality.[217]

188 For example, we specifically recommend that:

(a) a Mental Health Quality and Safety Committee should be set up within Safer Care Victoria, noting that there is significant expertise in quality improvement within Safer Care Victoria. This expert Committee should establish a suite of KPIs that are comprehensive, required by law and relevant to people with psychiatric disorders. I discuss the importance of outcome measurement and KPIs further from paragraph 168 above;

[216] See TAPI Submission, Section 8.3, p. 82.
[217] See Chapter 8, pp. 75-88. Three schematic diagrams at pp. 77-79 illustrate the major reforms proposed.

(b) a new service, quality and safety improvement role of the Chief Mental Health Officer should be created in addition to the role of the Chief Psychiatrist. In my view, the responsibilities of the Chief Psychiatrist as currently framed appear to be very onerous and difficult. As part of service improvement, the role of the Chief Psychiatrist should remain in place, but be redefined, especially to focus on regulation and compliance with the *Mental Health Act 2014* (Vic);

(c) there should be a Clinical Advisory Council advising the Director of Mental Health Branch. This is important because, from discussions with my psychiatric colleagues in the public mental health system, it is my understanding that there has not historically been sufficient clinical input from mental health clinicians into decision being made by the Mental Health Branch; and

(d) there should be ongoing very close communication between the Mental Health Branch and Safer Care Victoria.

189 Further, noting the recent restructure of the Health and Wellbeing Division of the DHHS, the Mental Health Branch should report directly to the Deputy Secretary for the Policy stream within that Division (as opposed to the Deputy Secretary for the Commissioning stream).

190 In relation to Ministerial responsibilities, I note that Victoria's first Mental Health Minister was appointed in 2006. In the TAPI Submission, we recommended that the Mental Health portfolio be absorbed within the broader Health portfolio, with responsibilities for mental health being re-assumed by the Minister for Health. One of the reasons for that recommendation was that, although cause and effect could not be established, it is a notable fact that funding for mental health on a per capita basis decreased from 2006 in comparison to both: a) per capita expenditure for mental health services in other states and territories; and b) the funding of acute health services in Victoria, with concerns that the voice of the Ministers of Mental Health over the past 14 years may not been heard as loudly as they should have been in Cabinet, because of the overwhelming demands within the broader Health Portfolio, which is overseen by the Minister for Health. Since the TAPI Submission was submitted, the Minister for Mental Health has been an increasingly prominent advocate and prime mover behind many new initiatives, including those associated with public mental health measures that have been introduced in response to COVID-19.[218]

The potential role of an independent Victorian Mental Health Commission

191 Around the country, there are mental health commissions in Western Australia, South Australia, New South Wales and Queensland. The annual investment in, and budget of

[218] These measures are discussed from paragraph 34 above.

each of those four mental health commissions varies widely,[219] which likely reflects the fact that each of those commissions has different roles.

192 My TAPI colleagues and I strongly endorse the role of the National Mental Health Commission in reporting, monitoring and evaluation. In my view, Victoria should not establish its own mental health commission because doing so would add an additional and unnecessary level of bureaucracy. In Victoria, we already have the Mental Health Complaints Commissioner and the Mental Health Tribunal, which are in addition to other government entities that are key components of the oversight of the mental health system.

193 Some people may argue that we should set up a Mental Health Commission in Victoria to ensure independent oversight of implementation of reforms to the mental health system – the idea is that the Mental Health Commission would be independent from government and would report annually on what has been done, and what needs to be done, to implement the agreed reforms. Whilst it could well do this, it would need to be granted unusual powers in comparison to other Mental Health Commissions to place effective pressure on the government of the day to ensure that its obligations toward the mental health system were being met, if the trajectory for change was heading in the wrong direction. That is one of the reasons, in addition to not wishing to see an additional layer of bureaucracy, that I do not recommend that establishment of such a Commission in our State.

Catchments

194 Currently, a significant component of mental health services is commissioned and delivered through the PHNs, especially through psychologists. Yet there is poor alignment of Area Mental Health Services (**AMHS**s) boundaries with the PHNs.

195 In addition, the AMHSs for children and for older adults are not the same as those for the general adult population. Further, as we state in the TAPI Submission, "specialised mental health services are often inconveniently divided across artificial geographical boundaries which reduce ease of access for patients."[220]

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[219] For details of investment, budgets and expenses of each of the four commissions, see: Mental Health Commission of New South Wales, 'Annual Report 2018-2019', <https://nswmentalhealthcommission.com.au/sites/default/files/documents/final_annual_report_2018-19_31_october_2019_0.pdf> [accessed 7 June 2020]; SA Mental Health Commission, '2018-19 Annual Report', <https://samentalhealthcommission.com.au/wp-content/uploads/SAMHC-Annual-Report2018-19.pdf> [accessed 7 June 2020]; Government of Western Australia Mental Health Commission, 'Annual Report 2018-19', <https://www.mhc.wa.gov.au/media/2712/mhc-annual-report-2018-19.pdf> [accessed 7 June 2020]; Queensland Mental Health Commission, 'Budget', <https://www.qmhc.qld.gov.au/about/corporate-information/budget> [accessed 7 June 2020].

[220] At p. 76. See also pp. 83-88, where we summarise the other issues with the current geographic catchment areas noted in the VAGO Report, 'Access to Mental Health Services', 2019.

Making State and Commonwealth service delivery coterminous – opportunities and challenges

196 Aligning the AMHSs within PHN boundaries is critical in order to make coterminous the State and Commonwealth delivery of mental health services. However, the areas established by the PHN boundaries, as currently defined, are too large for AMHSs to cover them; the areas are too large for mental health service providers to be able to understand and respond to local needs.

197 In addition, basing the catchment areas for State mental health services on the Commonwealth Government's current PHN model may prove problematic, because the Commonwealth may well change its approach to the within-State and Territory delivery of primary medical care that it directly funds. For example, it may decide to redefine the PHN boundaries or even move to a different model altogether.[221] This is a difficult challenge to surmount; we cannot bind the current (or any future) Commonwealth Government to agree to maintain the PHNs.

198 Ultimately, the Victorian Government will need to weigh up the likely longevity of the current PHN model, taking into account how the current arrangements are perceived across the political spectrum. It is therefore vital that any reforms made to catchment areas at State level are first discussed with the Commonwealth Government and, in my view, the Federal opposition.

Recommended approach to realigning mental health boundaries

199 My TAPI colleagues and I recommend that:

> "Area Mental Health Services (AMHSs) should be reconfigured to better align their catchment areas with other health and human service areas in order to improve service coordination and to enable within-area whole-of-life mental health care. Groups of AMHSs should sit within six new Mental Health Networks (MHNs), which geographically align closely with the existing Commonwealth Primary Health Networks (PHNs). The incorporation of AMHSs into MHNs would facilitate (1) coordination of services between AMHSs, and (2) integration of mental health services with other health and non-medical services – such as general practice, PHNs, housing, social welfare, and legal aid. There should be three sets of metropolitan and regional MHN pairs."[222]

[221] The impermanence of such arrangements is evidenced by the fact that the Commonwealth Government replaced the Divisions of General Practice in the 1990s with Medicare Locals in 2011, and with Primary Health Networks (more than halving the number of components) in 2015. In each case, the boundaries changed substantially.
[222] Recommendation 23. For further detail, see the discussion at Section 8.5, pp 83-86.

200 In redefining catchments, it is also important to align the catchment areas for different age groups so that when people transition from one age bracket or service to another, they remain within the same catchment area. AMHSs should also align with Local Government Areas (**LGA**s). The Victorian Department of Health considered this matter in some detail and stated in its consultation paper published in August 2013: "The boundaries of 12 LGAs (eight metropolitan, four rural) are split by mental health service boundaries. This is largely dysfunctional in the metropolitan area; however, rural arrangements tend to address practical geographical access."[223] In considering what could change for the future, the paper stated: "Splitting of LGA boundaries in the metropolitan area [should] … be largely eliminated, thereby setting the conditions for better planning alignment with other relevant service sectors."[224] An overlapping element in this regard is that epidemiological and clinical utilisation surveys often take into account LGA boundaries; if there is an admixture of inputs from different AHMSs within individual LGAs it will make it difficult to work out how various service inputs result different outcomes.

201 Realigning catchment areas so that AMHSs sit within the metropolitan and regional Mental Health Networks, and having Integration Hubs within those catchment areas, are important steps towards addressing the fragmentation and discontinuities in the mental health system.

Research

Research activities at specialist hospitals

202 As noted above, until very recently (30 June 2020) I was a Director of the Board of the RWH and Chair of the Research Committee of the RWH. I have also previously held various roles on the Board of the Peter MacCallum Cancer Centre, including Deputy Chairman of the Board and Chair of its Research Committee.

203 The RWH and the Peter MacCallum Cancer Centre highlight the capacity for specialist hospitals to undertake high levels of quality research. Both hospitals undertake substantial research activities, including clinical trials, grants success and publications. For example:

(a) at the RWH – which has 10 research centres – in 2018, there were 58 clinical trials and approximately 220 researchers, with a research publication output of 231 papers.[225]

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[223] Victorian Department of Health, Consultation Paper: 'Clinical mental health service catchments', August 2013, <https://www2.health.vic.gov.au/Api/downloadmedia/%7B4355303B-2D06-4190-AEC8-C78681867CD3%7D> [accessed 17 June 2020] at p. 17.
[224] Ibid.
[225] The Women's Research Report, 'Better Together: Improving care through collaboration', 2018, p. 3, available at <https://thewomens.r.worldssl.net/images/uploads/general-downloads/reports-publications/rwh-research-report-2018.pdf> [accessed 6 July 2020].

(b) at the Peter MacCallum Cancer Centre, the 2019 research budget was $90 million and there were 45 research laboratories, 656 dedicated cancer researchers, 213 active clinical trials, 725 research articles published with 115 published in high impact journals; [226]

204 It is my hope that patients in the Victorian mental health system of the future will be enrolled in clinical trials and studies as is currently the case for patients at the Peter MacCallum Cancer Centre. It will only be through carefully designed studies that we will be able to ensure that clinical care is based on high level evidence, rather than, for example, 'clinical wisdom'. Clinical trials are a major driver for improving patient care – they help to move the field of medicine forward. This is especially relevant for people who have illnesses that are difficult to treat. Importantly, participants in clinical trials at specialist hospitals are generally given the trial treatment (or placebo) in addition to existing treatments, meaning no participants go without treatment.

Research and clinical trials in mental health

Current state

205 There has been a well-documented reduction in funding of mental health research. Data show that NHMRC funding for mental health research declined from around $97 million in 2014-15 to around $69 million in 2017-18.[227] The insufficient investment in mental health research is reflected in:

(a) the paucity of clinical trials in psychosis in Victoria and Australia;[228]

(b) the absence of psychiatry/mental health in clinical trials alliances, such as the national peak body, the Australian Clinical Trials Alliance;[229] and

(c) the need to establish clinical registers in various mental illnesses (which I discuss from paragraph 176 above).

206 Regrettably, clinical trials have not commonly been used to test new treatments for mental health issues. In my view, a likely reason why clinical trials are not commonplace in mental health is that the public mental health system is so stretched and crisis-driven,

[226] Peter MacCallum, 'Cancer Centre, Annual Report 2018-2019', p. 5, available at <https://www.petermac.org/sites/default/files/media-uploads/PM0033_AnnualReport_2019_FINAL.pdf.> [accessed 6 July 2020].
[227] Australian Government, Productivity Commission, 'Report on Government Services 2020', 25 June 2020, see Table 13 A2, <https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/health/mental-health-management> [accessed 6 July 2020].
[228] Taking into account what I regard as misclassifications, it is my assessment that fewer than 20 clinical trials in Victoria of treatment for schizophrenia or psychosis are registered with the Australian Clinical Trials, 'Search for a Clinical Trial' <https://www.australianclinicaltrials.gov.au/anzctr_feed/form> [accessed 12 June 2020].
[229] See the list of members at Australian Clinical Trials Alliance, 'Current ACTA Members', <https://clinicaltrialsalliance.org.au/about-acta/acta-members/> [accessed 3 July 2020].

and patients are given such drastically short stays in hospitals that there is little opportunity to begin treatment and enrol people in clinical trials.

207 One of the unfortunate results of dispersing mental health units throughout general hospitals is that these hospitals lack critical mass for mental health research. Currently, mental health research in public hospitals takes place in a far too fragmented manner across the State.

208 In contrast, Orygen Youth Health, which specialises in youth mental health research (and care), is a very good example of a best practice approach to research. Their research is of a very high standard. A key reason for Orygen's success in youth mental health research is that they have a critical mass of accomplished researchers and strong national and international partnerships.[230]

Looking to the future

209 My TAPI colleagues and I recommend that "Victoria should aim to be a world-leading centre for serious mental illness research and discovery, significantly increasing serious mental illness research spending and capacity – from bench to the bedside."[231]

210 There will be a translational research component in the new Victorian Collaborative Centre for Mental Health and Wellbeing. It is important for this component to be seen as a key element within the Centre. It is my experience that, given the necessarily primary focus on clinical care, it is important to protect and advocate for the appropriate allocation of funds to support clinical research, even in relatively research-intensive hospitals.

211 Whether coordinated by the Collaborative Centre or otherwise, there should be a greater coordinated research effort in the area of mental health. Just as Clinical Trial Networks are used in other fields of medicine, there needs to be a concerted effort to link up research groups in hospitals and universities in Victoria with a wide range of researchers with expertise in psychiatry and other aspects of mental health.

212 In addition, clinical trials should become the tradition in mental health, including in the public system. This will require a change in philosophy, a less crisis-driven system and a deep commitment to evidence-based clinical research that we see in specialist hospitals such as the RWH and the Peter MacCallum Cancer Centre, and that we will see at the Victorian Heart Hospital, once it opens in 2022.

[230] See Orygen, 'Research', <https://www.orygen.org.au/Research> [accessed 3 July 2020].
[231] Recommendation 17. See Section 7, pp. 73-74.

Prevention

A note on terminology and the context for my evidence on prevention

213 I would like to explain the context in which I am about to address the topic of 'prevention':

(a) first, I am not an expert in the area of prevention. I have, however read a considerable number of papers in the area and had many discussions with a wide range of colleagues about the topic;[232] and

(b) secondly, I have been somewhat reticent about making comments in relation to this topic in the past because the most notable proponent of the prevention of psychotic disorders in Australia is a friend of mine, Professor Pat McGorry AO – and I do not wish him to feel that I am taking issue – to the extent that I am doing so in relation to prevention – with him personally, in contrast to how I view the data on the topic. In fact, with the exception of the TAPI Submission,[233] I have deliberately refrained from writing about the topic of 'prevention' in academic journals, even after having been invited to do so by some of my TAPI colleagues on a number of occasions.

214 The two primary reasons for which I feel it is important to share my reflections on this issue in response to matters requested by the Royal Commission are:

(a) first, in my view, use of the term 'prevention' is overused in mental health to the extent that it implies that the serious psychiatric illnesses, in particular, can be prevented from ever occurring. The evidence does not match the assumption of efficacy; and

(b) secondly, I believe that the terms 'early intervention' and 'prevention' are often used together in a way that implies that 'early intervention' is likely to lead to 'prevention' (in the primary and indicated senses, as explained further below),

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[232] There are a number of contentious issues in relation to early intervention and prevention. In addition to the publications referenced throughout this section, the following articles also take different perspectives on this important issue: Stephen Allison et al, 'Does early intervention prevent chronic psychosis? A question for the Victorian Royal Commission into Mental Health'. *Australian & New Zealand Journal of Psychiatry*, 53.10 (2019), 943-945; Alison Yung et al, 'The value of early intervention in creating the new mental health system: Response to Allison et al', *Australian & New Zealand Journal of Psychiatry,* 54.7 (2020) 667-669 <https://doi.org/10.1177/0004867420925169> [accessed 6 July 2020]; Donald Goff, Chenxing Li and Lorna Thorpe, 'Does early intervention improve the long-term course of schizophrenia?', *American Journal of Psychiatry,* 177.4 (2020) 288-290; Katherine Jonas et al, 'Lead-Time Bias Confounds Association Between Duration of Untreated Psychosis and Illness Course in Schizophrenia', *American Journal of Psychiatry*, 177.4 (2020) 327-334; David Castle and Swaran P Singh, 'Early intervention in psychosis: still the 'best buy'?' *The British Journal of Psychiatry: the journal of mental science*, 207.4 (2018) 288-92; Wenche ten Velden Hegelstad et al. 'Long-term follow-up of the TIPS early detection in psychosis study: effects on 10-year outcome', *American Journal of Psychiatry* 169.4 (2012) 374-380.

[233] Page vii. See further the discussion of prevention (including 'indicated prevention') in Chapter 3, pp. 29-33.

when there are insufficient data to demonstrate this to be the case in relation to psychotic disorders.

215 As a prelude to providing some personal reflections on prevention which 'go against the grain' of many experts in the area, I would like to consider the role that the main proponent of the prevention and early intervention of psychosis in Australia, Professor McGorry AO and his colleagues at Orygen have played in psychiatry in our State and our country. There is no question that, as Minister Greg Hunt recently observed, because of Orygen, Australia is seen as being the leading nation in Youth Mental Health. [234] The recent announcement of a set of grants worth $11.9 million from the UK's Wellcome Trust, is a major endorsement of that standing in the international arena.[235]

216 Funding of this magnitude and the uptake of Orygen's and headspace's early intervention models in 15 countries around the world brings many advantages to Victoria and to Australia. It brings health improvements and hope to young people who are suffering from psychiatric disorders and also to researchers in youth mental health, especially given the precarious future for many researchers in the wake of COVID-19, with estimates coming from the RRIF paper that Australia could lose 7,000 research positions in universities and 3,000 positions in medical research institutes as a result of COVID-19.[236]

217 In speaking to my colleagues who, unlike me, work in the public mental health sector, there is the view that Youth Mental Health is a more 'magnetic destination' for public and Ministerial interest and attention than other areas of mental health (especially those relating to chronically ill older adults with complex needs) – with positive ramifications for funding-related decision-making. This is partly the result of the message of hope that young people naturally elicit in others, augmented by the message of hope that is core to the Youth Mental Health ethos, as well as the tailwind that Orygen is travelling in as a result of its successful enterprise over three decades. There is a general perception amongst those I have spoken to within the public mental health sector that there is something akin to a 'two speed economy' in mental health, with Youth Mental Health being in the fast lane. In providing the following examples, I do so to suggest that the rest

[234] Speech by Minister Hunt, 24 June 2020, available at Orygen's twitter page, <https://t.co/KoGbDBbtjm> [accessed 29 June 2020].
[235] Orygen, 'Wellcome Trust delivers $11.9 million boost to Orygen's early psychosis research', 24 June 2020, <https://www.orygen.org.au/About/News-And-Events/2020/Wellcome-Trust-delivers-$11-9-million-boost-to-Ory> [accessed 29 June 2020].
[236] See letter by Lead Author Professor Frank Larkins, addressing the question: 'What impact is the pandemic having and likely to have on Australia's research workforce and its capability to support our recovery efforts?', 8 May 2020, <https://www.chiefscientist.gov.au/sites/default/files/2020-05/rrif-covid19-research-workforce.pdf> [accessed 29 June 2020] at p.5.

of psychiatry needs to follow the lead that has been set by Youth Mental Health, with some apparent examples being:

(a) at the Commonwealth level, a combined $373 million was allocated in the 2019-20 budget for the following seven years for headspace and Early Psychosis Prevention and Intervention Centres;[237] this was more than three times higher than the allocation of funds to trial specialised mental health support services for adults ($114.5 million),[238] despite the fact that there are more than 7.5 times as many adults aged 25-64 (13.3 million) than youth aged 20-24 (1.75 million);[239]

(b) Victorian expenditure on general adult mental health services per capita increased by 1.8% between 2013-14 and 2017-8, whereas during the same time period expenditure on youth mental health services per capita increased by 15%;[240]

(c) Orygen has been provided with outstanding, world class facilities by means of a partnership allocation of $78 million; this funding provides it with an excellent base from which to achieve even better outcomes on the clinical care and research horizon.[241] The location of these facilities may be one reason why—as I understand it—all of the new acute inpatient public youth mental health beds will be established in the North West (and in Barwon Health) as a result of the recommendations of the Royal Commission's Interim Report, despite all the current Youth Mental Health beds being located in the North West.[242] The rationale for this allocation is in apparent contrast with the rationale for allocating new adult beds to the North West and to the Barwon region which was to allocate them to the services "with the most pressing current and forecast demand pressures on the basis of population growth and bed availability",[243] with Barwon

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[237] Commonwealth Government, 'Budget Measures Budget Paper No. 2: 2019-20' <https://budget.gov.au/2019-20/content/bp2/download/bp2.pdf> [accessed 29 June 2020] at pp. 103-105.
[238] Ibid at p. 104.
[239] Australian Bureau of Statistics, '3101.0 - Australian Demographic Statistics, Dec 2019, Population by Age and Sex Tables' <https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3101.0Dec%202019?OpenDocument> [accessed 29 June 2020] at Table 8.
[240] Australian Institute of Health and Welfare, 'Expenditure on mental health-related services' January 2020, see Table EXP.12: Recurrent expenditure per capita ($) on specialised mental health care services, constant prices, by target population, states and territories, 2005–2006 to 2017–2018, rows 20 and 22, available for download at <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services> [accessed 6 July 2020].
[241] Orygen, 'Premier visits world's first facility focused on youth mental health research, clinical care and service reform as it nears completion', 25 October 2018 <https://www.orygen.org.au/About/News-And-Events/2018/Premier-visits-world%E2%80%99s-first-facility-focused-on-y> [accessed 29 June 2020].
[242] This assumes that the new Youth Mental Health beds will form part of the 135 additional acute inpatient public mental health beds (which are to be proportionally provided to Barwon Health and to Melbourne Heath), and not the 35 additional acute inpatient mental health beds to be delivered by a private provider (for which the Royal Commission's Interim Report does not specify a location). See also Victorian Auditor-General's Office, 'Child and Youth Mental Health' <https://www.audit.vic.gov.au/report/child-and-youth-mental-health?section=33207--2-design-of-child-and-youth-mental-health-services> [accessed 5 July 2020].
[243] Interim Report, p. 431.

Health and Melbourne Health having the lowest current and projected number of beds per 100,000 of the population.[244]

218 The implications of this unequivocal success of advocacy and recognition of need for Youth Mental Health services and research is the wish for:

(a) the great momentum in Youth Mental Health to be maintained and supported by State and Commonwealth Governments, funding and philanthropic agencies and the public; and

(b) psychiatric care and research relating to other age groups to be provided with the resources to 'catch up' with Youth Mental Health (this will need turbocharged funding for these age-related care and research areas) and to remain in lock-step with the fast rate of progress in the area of Youth Mental Health.

219 By way of example, funding for Adult Psychiatric research in Victoria should aspire to reach the levels and scope of research activities undertaken in the Charité Hospital System, one of the largest university hospitals in Europe.[245] My understanding is that:

(a) there are approximately 3,700 researchers within the Charité hospital system who are engaged in a wide range of medical research programs;

(b) the Department of Psychiatry and Psychotherapy is the leading research department within Charité;

(c) there is a particular focus on the interface between basic and patient-oriented research, which involves interdisciplinary collaborations with both national and international partners;

(d) psychiatric research – including into schizophrenia and depression – as well as neurological and neuroscientific research, takes places within the Cluster of Excellence called NeuroCure, which is a joint initiative of Charité, its two parent universities (Humboldt Universität zu Berlin and Freie Universität Berlin), and important non-university-institutions including the Max Delbrück Center for Molecular Medicine Berlin-Buch (MDC), and the Leibniz-Institut für Molekulare Pharmakologie (FMP); and

(e) NeuroCure is comprised of more than 50 research groups. Funding levels are high (approximately €3.5 million per annum) and the impact factors associated with their peer-reviewed publications are also high.[246]

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[244] Interim Report, Figure 14.7, p. 430.
[245] Charité, 'Department of Psychiatry and Psychotherapy (CCM) <https://psychiatrie-psychotherapie.charite.de/en/research/> [accessed 1 July 2020].
[246] My evidence about the Charité Hospital System is informed by Professor Andreas Heinz, President of the German Psychiatric Association (DGPPN).

220 The turbo-charging required for Adult Psychiatry[247] should not be postponed until the Victorian Collaborative Centre for Mental Health and Well-being is established, because that is likely to take several years.[248]

Reflections on Early Intervention; defending the right to critically assess some components of it

221 I am a strong advocate for early intervention in the treatment of people with psychiatric disorders, if that can be achieved. Being critical of early intervention in its broadest sense would be like being critical of the concept that mental health professionals should be compassionate towards their patients. But it is my view that some early intervention advocates do not sufficiently recognise (or at least do not sufficiently do so in their publications) that criticisms about certain elements of the assertions made by protagonists of early intervention and prevention, are not tantamount to criticising the broad and, one might say, yet to be precisely defined (omnibus) concept of 'early intervention'. Those who question these 'sub-elements' should not be considered pessimists, conservatives, denialists or "merchants of doubt".[249] Scientific research and discourse should always incorporate and be welcoming of the testing and challenging of hypotheses; in other words, the discourse should take place in a spirit of constructive scepticism.

222 The absence of large numbers of positive and replicable studies does not mean that a treatment has been proven to be ineffective on a population basis (or that some or many individuals may not benefit from it); rather it is the basis upon which one might say that there is an insufficient body of evidence to prove that it is effective. With that in mind and in relation to Early Intervention and Prevention of psychosis, it is, in my view, reasonable to consider the following subcomponents:

(a) whether primary prevention is possible, i.e. preventing psychosis from ever occurring;

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[247] See TAPI Submission at pp. 8-21.

[248] As a comparator, there was an interval of seven years between the announcement of funding for the new Peter MacCallum Cancer Centre (in 2009) and the opening of the new hospital in Parkville (in 2016): Nick Miller, 'New cancer centre 'one of the world's best', *The Sydney Morning Herald*, 7 May 2009, <https://www.smh.com.au/national/new-cancer-centre-one-of-worlds-best-20090507-aw3d.html> [accessed 29 June 2020]; and Peter MacCallum Cancer Centre, 'Top 10 historical events of Peter Mac' <https://www.petermac.org/about/our-history/top-10-historical-events-peter-mac> [accessed 29 June 2020].

[249] This term was used to criticise some of the critics of aspects of early intervention in: Patrick D McGorry and Cristina Mei. 'Why do psychiatrists doubt the value of early intervention? The power of illusion', *Australasian Psychiatry*, 28.3, (2020), 331 334, <https://doi.org/10.1177/1039856220924323> [accessed 6 July 2020]. The following book describes how handfuls of scientists can cast serious doubt on extremely well-established bodies of knowledge – with a focus on climate change and the cancer-causing properties of tobacco smoke: Naomi Oreskes and Erik M Conway, *Merchants of Doubt: How a Handful of Scientists Obscured the Truth on Issues from Tobacco Smoke to Global Warming* (Bloomsbury Press, 2010). I note that evidence for the existence of anthropogenic climate change and the carcinogenic properties of tobacco is very much stronger than, for example, the primary and indicated preventive capabilities of early intervention in psychotic disorders.

(b) indicated prevention – whether there is convincing evidence that any specific interventions clearly demonstrate superior efficacy above and beyond standard care;

(c) whether early intervention has long-standing benefits, in addition to the clear short-term benefits that occur during treatment and for a small number of years afterwards; and

(d) whether Early Intervention services (as pioneered by Orygen) should now be incorporated throughout the adult mental health system, rather than being provided in an age-specific service.

223 I discuss the first three questions in some detail below, leaving the fourth question to be answered this way: yes, early intervention should be increasingly incorporated in treatment across the age ranges, as long as it is not seen to be of 'superior standing' in relation to other stages of care, which may be unable to be 'brought forward'. In this regard, I have insufficient knowledge of the research literature on whether, on the whole, the carving out of Youth Mental Health provides better care than for the designated age group than in mental health systems that do not do so. That said, some of these issues are far from settled. As I previously noted, those who raise questions about them should not be considered as being critical in any 'overall sense' about the concept of Early Intervention.

What is meant by prevention – in common parlance and also by mental health professionals

224 'Preventing' mental illness has been a goal of many policymakers and practitioners over the years. For example, for the National Committee for Mental Hygiene and the many programs that arose as a result of it began in the United States just prior to World War One. Its first Medical Director was Dr Thomas Salmon, whose focus was on treating the young. To use language of the time, which I do not endorse: "The plan was to treat incipient cases of insanity among children and adults, to slow or reverse the remorseless increase in the number of mental patients confined in state mental hospitals."[250] In 1963, President Kennedy set in train a program to prevent mental illness[251] – an aspiration that has become increasingly yearned-for over the decades, for reasons that are both obvious

[250] Andrew Scull, 'Creating a new psychiatry: on the origins of non-institutional psychiatry in the USA, 1900–50', *History of Psychiatry* 29.4 (2018), 389 at p. 392. The National Committee for Mental Hygiene was driven by someone who had been treated in a psychiatric hospital, Clifford Beers. Just over twenty years after the establishment of the Mental Hygiene movement, Alan Gregg, who was the Director of the Division of Medical Sciences in 1930 reported in his official diary that "'mental hygiene has been much oversold and expectations excited beyond likelihood of gratification' – a feeling that he found was 'widespread' as he travelled around the country." at p 393.

[251] John F. Kennedy, 'Special Message to the Congress on Mental Illness and Mental Retardation' February 5, 1963. Online by Gerhard Peters and John T. Woolley, The American Presidency Project, <https://www.presidency.ucsb.edu/documents/special-message-the-congress-mental-illness-and-mental-retardation> [accessed 15 June 2020].

and meritorious. Turning to the present day, the terms of reference for the Royal Commission focus on how Victoria's mental health system can most effectively prevent mental illness.

a) The common understanding of 'prevention'

225 It is my opinion that most people in the general community would understand the word 'prevention' to simply mean: preventing an illness from occurring that would otherwise have affected a person.

226 It is important to clearly distinguish between primary prevention, and secondary and tertiary prevention of mental illness. My colleagues at TAPI and I agree with New South Wales Health's definition of these terms, namely that:

(a) primary prevention reduces the likelihood of developing a disease or disorder;

(b) secondary prevention interrupts, prevents or minimises the progress of a disease or disorder at an early stage; and

(c) tertiary prevention halts the progression of damage already done.[252]

227 Adopting that definition, and with respect to primary prevention, we can prevent and have prevented lung cancer by public health measures that reduce cigarette smoking; we can prevent type 2 diabetes by encouraging people to improve their diet and exercise regimens; and we can prevent a person from getting malaria by providing them with anti-malarial medication before they travel to and whilst they reside in a malaria-ridden region. But there are many illnesses and diseases that cannot be prevented, such as rheumatoid arthritis, type 1 diabetes, Crohn's disease, motor neurone disease, multiple sclerosis, Parkinson's disease and the main form of pulmonary fibrosis. Two other illnesses that cannot be prevented in the commonly understood sense of (primary) prevention – that people who would otherwise develop the illness do not do so – are schizophrenia[253] and bipolar mood disorder.[254]

228 This is in contrast to depression and anxiety[255] where there is some evidence for primary prevention. Even in relation to the latest data on the prevention of suicide, the evidence

[252] TAPI Submission, p. 29 citing South Western Sydney Local Health District, 'Providing High Quality Health Services: Secondary Prevention', June 2016, <https://www.swslhd.health.nsw.gov.au/populationhealth/pdf/news11.pdf> [accessed 25 May 2020] at p.1.
[253] Paolo Fusar-Poli, Patrick D McGorry and John M Kane, 'Improving outcomes of first-episode psychosis: an overview', *World Psychiatry*, 16.3 (2017) 251-265, <https://doi.org/10.1002/wps.20446> [accessed 6 July 2020].
[254] Marsal Sanches and Jair Soares, (2020). Prevention of Bipolar Disorder: Are We Almost There?. *Current Behavioral Neuroscience Reports*. 7. 10.1007/s40473-020-00203-8.
[255] Kim van Zoonen et al, 'Preventing the onset of major depressive disorder: a meta-analytic review of psychological interventions', *International Journal of Epidemiology*, 43.2 (2014) 318–329, <https://doi.org/10.1093/ije/dyt175> [accessed 6 July 2020]; Richard F Muñoz et al, 'Prevention of major depression', *Annual Review of Clinical Psychology* 6 (2010) 181-212; E A Stockings et.al, 'Preventing

that I had assumed was reasonably strong is far from being so, when large numbers of studies are considered,[256] albeit with notable exceptions.[257] In my view, what I consider to be the overuse of the term 'prevention' in relation to psychosis risks giving false hope to the community and to decision-makers about being able to prevent these severe mental illnesses from ever occurring. For example, to the extent to which the name "Early Psychosis Prevention and Intervention Centre" suggests that one can prevent psychotic disorders, in the primary prevention sense, it is a name that privileges aspiration over reality. By way of analogy, if one were to set up a clinic and call it 'The Multiple Sclerosis Prevention and Early Intervention Clinic', that would most likely cause neurologists to be critical, because the name suggests that it is possible to prevent multiple sclerosis from ever occurring, when in fact nobody can do that (even though relapse prevention and the modulation of illness progression are very much a clinical reality,[258] just as they are with psychotic disorders).

229 It is my view that, despite the huge progress that has been made in the diagnosis and treatment of mental illnesses over recent decades, we have no tools in our armamentarium that have been shown to prevent psychotic illness, in the primary sense and at a population level.[259] That is partly because, although we now know vastly more about many of the factors that, in combination, potentially modify the risk of psychotic disorders, including genes of influence and adverse psychosocial circumstances, with the exception of the very difficult-to-achieve goal of reducing the use of high-potency recreational drugs in the community,[260] we are yet to identify specific risk factors that are likely to lead us in the foreseeable future to "tractable" interventions that will prevent these illnesses from occurring. To clarify this point, reducing the incidence of risk factors for psychosis such as obstetric complications and adverse events in both childhood and adult life[261] should be pursued in their own right, as a public good (but not from the very limited mental health budget); but identifying that a particular factor has been shown to contribute to an increased risk of psychosis is quite different to, and much more difficult than

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Depression and Anxiety in Young People: A Review of the Joint Efficacy of Universal, Selective and Indicated Prevention', *Psychological Medicine*, 46.1 (2016) 11-26.

[256] Gil Zalsman, et al, 'Suicide prevention strategies revisited: 10-year systematic review' *Lancet Psychiatry*, 3.7 (2016) 646-659, https://doi.org/10.1016/S2215-0366(16)30030-X [accessed 6 July 2020]; Kristen E D'Anci et al, 'Treatments for the Prevention and Management of Suicide: A Systematic Review' *Annals of Internal Medicine* 171.5 (2019) 334-342. doi:10.7326/M19-0869.

[257] One exception is the restriction of means of suicide: Julia Buus Florentine and Catherine Crane, 'Suicide prevention by limiting access to methods: A review of theory and practice' *Social Science & Medicine* 70.1 (2010) 1626-1632. See also the discussion of the use of pharmacological agents such as lithium and clozapine in the TAPI Submission at pp 31-32.

[258] Michael J Olek and Ellen Mowry, 'Disease-modifying treatment of relapsing-remitting multiple sclerosis in adults' *UpToDate,* 3 June 2020, <https://www.uptodate.com/contents/disease-modifying-treatment-of-relapsing-remitting-multiple-sclerosis-in-adults> [accessed 14 June 2020].

[259] In that sense, we are just like Dr Thomas Salmon and his colleagues on the National Committee for Mental Hygiene at the turn of the last century (see footnote 250 above).

[260] Olesya Ajnakina, Anthony S David and Robin M Murray, 'At risk mental state' clinics for psychosis–an idea whose time has come–and gone!', *Psychological Medicine*, 49.4 (2019), 529-534.

[261] Ibid.

demonstrating that *modification* of that risk factor results in a lower incidence of the disorder.

230 Although I have commented about hope being a valuable attribute, that is not an unqualified endorsement of it in relation to psychotic illnesses, many of which have outcomes that are much less favourable than all of us would wish.[262] My reading of the prevention of psychosis literature is that it tends to use words and phrases such as "promising" and "hoped-for" to an extent that is not justified by existing and replicable data. For example, the former Director of the most prestigious mental health research organisation in the world, the National Institute of Mental Health in the United States, Dr Tom Insel, published a paper ten years ago in which he wrote:

> "If the preemptive interventions are as effective as what we have today for coronary artery disease and if these are widely deployed, by 2030 we should expect a profound reduction in first-episode psychosis."[263]

Based on current data, there is no prospect for such a massive reduction in first episode psychosis to take place within the next ten years.

231 The corollary of these reflections is that, in my opinion, the aspiration of (primary and indicated[264]) prevention of psychosis should be examined closely by the Royal Commission; this examination should take place not on the basis of whether it is a *worthy* goal, which it most certainly is, but whether the data supporting it can justify the extent to which prevention at these levels is a *realisable* goal. This examination should also assess whether the data justify the basis for planning and funding services, as against providing a most worthwhile research agenda in the years ahead. Further, there needs to be a greater focus and emphasis on *the provision of mental health care and treatment*, especially for those with serious mental illness who require such care and treatment, who either do not receive clinical treatment at all[265] or who receive it in a manner that is grossly sup-optimal.[266]

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[262] See TAPI Submission at pages 10-12.

[263] Thomas R Insel, 'Rethinking schizophrenia', *Nature*, 468 (2010) 187-193, <https://doi.org/10.1038/nature09552> accessed on 3 July 2020]. Insel was the Director of the National Institute of Mental Health in the United States from 2002-2015.

[264] Institute of Medicine (US) Committee on Prevention of Mental Disorders, P J Mrazek and R J Haggerty, eds. 'Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research'. (Washington (DC): National Academies Press (US) 1994), which states: "An *indicated preventive measure* applies to persons who, on examination, are found to manifest a risk factor, condition, or abnormality that identifies them, individually, as being at high risk for the future development of a disease." (at p.2, New Directions in Definitions', available from: <https://www.ncbi.nlm.nih.gov/books/NBK236318/> [accessed 2 July 2020]).

[265] Victorian Auditor General's Office, 'Access to Mental Health Services', March 2019 <https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf> [accessed 15 June 2020] at Figure 3E, p. 44.

[266] The Chair of the Royal Commission stated in November 2019 that "the system is woefully unprepared for current and future mental health challenges": Melissa Davey, 'Victoria to introduce mental health tax after royal commission finds it 'woefully unprepared'', *The Guardian*, 28 November 2019,

Early intervention for people at high risk of psychosis and those with first episode psychoses

232 There are two elements of prevention and early intervention in Youth Mental Health which sometimes get concatenated, namely:

(a) treating people who are thought to be at significant risk for developing psychotic illness, for example in prodromal clinics, before some of them develop psychotic symptoms. People who may develop psychosis are often described as having Clinical High Risk for Psychosis. One of the key goals of these clinics is to prevent psychosis from developing in at-risk individuals – if achieved, this is called 'indicated prevention'; and, separately

(b) treating people early once they have developed psychosis for the first time and early in the course of their illnesses.

It is important to consider these two areas separately.

<u>The efficacy (or otherwise) of prodromal or 'at risk' clinics for psychosis</u>

233 A recently published paper by Fusar-Poli and colleagues describes the diagnosis, prognosis and treatment of people with Clinical High Risk for Psychosis.[267] It is an umbrella study which looks at 42 meta-analyses of data and concludes that no treatment (including control/standard care) is better than any other treatment in preventing the onset of psychosis. In my view, it is a very important paper.

234 The findings of Fusar-Poli and colleagues are also supported by a 2019 Cochrane Review of interventions for the prodromal stage of psychosis, which showed there is no clear, strong evidence that particular interventions can prevent psychosis from developing.[268] Taken together, this research indicates that no treatment has shown superiority over any other treatment for preventing transition to psychosis, and the transition rate (to psychosis) is about 20%.[269]

235 A further paper published in 2019 supports the conclusion that prodromal clinics do not provide an efficient or effective mechanism to prevent first episode psychosis.[270] To quote

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<https://www.theguardian.com/australia-news/2019/nov/28/victoria-to-introduce-mental-health-tax-after-royal-commission-finds-it-woefully-unprepared> [accessed 29 June 2020].

[267] Paolo Fusar-Poli et al, 'Prevention of psychosis: advances in detection, prognosis, and intervention'. *JAMA Psychiatry,* 77.7 (2020), 755-765, <https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2762529> [accessed 6 July 2020].

[268] Dina Bosnjak Kujaric et al, 'Interventions for prodromal stage of psychosis', *Cochrane Database of Systematic Reviews*, 11 (2019), Article No. CD012236 <https://doi.org/10.1002/14651858.CD012236.pub2> [accessed 3 July 2020].

[269] Paolo Fusar-Poli et al, 'Prevention of psychosis: advances in detection, prognosis, and intervention' *JAMA Psychiatry*, 77.7 (2020) 755-765, <https://pubmed.ncbi.nlm.nih.gov/32159746/> [accessed 6 July 2020] at p. 758 (referring to a transition rate of 22% at 3 years).

[270] Olesya Ajnakina, Anthony S David and Robin M Murray, 'At risk mental state' clinics for psychosis–an idea whose time has come–and gone!'. *Psychological medicine*, 49.4 (2019), 529-534.

the authors: "We conclude that the task of reaching sufficient people to make a major contribution to the prevention of psychosis is beyond the power of [At Risk Mental State (**ARMS**)] Clinics."[271] The authors found that only 4% of the First Episode psychosis patients seen in the area served by the South London and Maudsley Trust had previously been seen at the ARMS Clinic which serviced the same area.[272]

236 A recent paper by Zhang and colleagues reports a study of 517 individuals at clinically high risk (CHR) of developing psychosis.[273] The authors conclude: "Administration of antipsychotics to CHR patients is potentially harmful with no preventive benefits. We do not recommend antipsychotic treatment for CHR individuals".[274] It is important to mention that over the years there has been a growing move away from recommending the use of antipsychotic drugs in the treatment of CHR patients. Despite that fact, a national survey of early psychosis services in the UK showed that, contrary to guidelines, 50% of services offered antipsychotic treatment to patients at high risk of psychosis.[275]

237 In earlier responses to both the Fusar-Poli et al and Cochrane Review, advocates for an indicated prevention approach have criticised the meta-analytic methodology as possibly being inadequate and not sophisticated enough to "see the trees for the wood" – in other words (by my understanding), to appreciate that there are important positive prevention signals buried within the overarching negative conclusions. Instead, they recommended different methods of considering the evidence including risk stratification and enrichment via sub-groups. They also suggested that critics of indicated prevention fail to appreciate the benefit in broadly supporting an area of research that gives patients and their families hope.[276] I agree that young people at risk of psychosis need to be given hope, but that is a separate issue to that of whether there is strong and replicable evidence to support any specific treatment as having efficacy for the indicated prevention of psychosis.

238 In this regard, it is relevant to note that the Orygen researcher who received the largest of the three recent Wellcome grants, Professor Paul Amminger, will be investigating, in a study involving more than 400 patients, the potential benefits of cannabidiol in preventing the onset of psychosis in those possibly at risk of developing it.[277] Professor Amminger

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[271] Ibid, see Abstract, at p. 529.
[272] See also Olesya Ajnakina et al, 'Only a small proportion of patients with first episode psychosis come via prodromal services: a retrospective survey of a large UK mental health programme' *Schizophrenia Bulletin,* 44.1 (2018), pp.S58-S58 (also published in *BMC Psychiatry.* 17.1 (2017) 308 <https://doi.org/10.1186/s12888-017-1468-y> [accessed 3 July 2020]).
[273] Tian Hong Zhang et al, 'Real-world Effectiveness of Antipsychotic Treatment in Psychosis Prevention in a 3-year Cohort of 517 Individuals at Clinical High Risk from the SHARP; (ShangHai At Risk for Psychosis)' *Australian and New Zealand Journal of Psychiatry,* 54.7 (2020) 697-706, <https://journals.sagepub.com/doi/pdf/10.1177/0004867420917449> [accessed on 6 July 2020].
[274] Ibid. See Abstract at p. 696.
[275] Helen J Swain et al, 'Research and practice for ultra-high risk for psychosis: A national survey of early intervention in psychosis services in England', *Early Intervention in Psychiatry,* 13.1 (2019) 47-52.
[276] Patrick D McGorry and Barnaby Nelson, 'Clinical High Risk for Psychosis—Not Seeing the Trees for the Wood'. *JAMA Psychiatry,* 77.7 (2020), 559-560, doi:10.1001/jamapsychiatry.2019.4635.
[277] Orygen, 'International charity commits $7 million to trialling cannabidiol in early psychosis', 23 June 2020, <https://www.orygen.org.au/About/News-And-Events/2020/International-charity-commits-$7-million-to-

has acknowledged the importance of the negative findings of the meta-analytic study by Fusar-Poli and colleagues, saying: "The most recent meta-analysis found no evidence to favour any specific intervention over others for psychosis prevention." [278] Professor Amminger has referred to the lack of currently identifiable effective preventative measures, to explain why Orygen's research in this area is so important – which it clearly is.

Early intervention for first episode patients

239 Research of the effectiveness of early intervention treatment for first episode patients (i.e. people who have developed psychosis) has generally and substantively demonstrated that those services have considerable value during the time they are being provided and for] up to two years afterwards. For example, the ten-year follow-up of the OPUS specialized early intervention trial for patients with a first episode of psychosis describes the positive effects of early intervention at two years after completion of treatment. However, with the possible exception of accommodation, those positive effects are diluted over the longer term, a "near absence" of any benefits at 10 years post-intervention.[279] A recent systematic literature review echoed the results from the OPUS study, reporting a dearth of evidence to demonstrate significant benefits in the long-term from intervention.[280]

240 The OPUS results do not diminish in any way the importance of the care that is provided during those initial phases after a person's first episode, or indeed any subsequent episode of psychosis. However, they do indicate that early intervention in first episode illness cannot be relied upon to reduce the level of demand for the provision of care in general adult mental health services. Advocates for indicated prevention and early intervention in first episode psychosis correctly point out that a hoped-for reduction of mental healthcare expenditures later in life is not the primary reason for such early interventions.

241 Politicians and policy makers may have been influenced in their decision-making by the dream of "bending the curve"[281] of psychosis outcomes. However, there is no compelling evidence that this most worthy aspiration in most domains of psychopathology and level

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triall> [accessed 29 June 2020]. Cannabidiol is a non-intoxicating component of the Cannabis plant – one of dozens of its constituent cannabinoids.

[278] Ibid.

[279] Rikke Gry Secher et al, 'Ten-year follow-up of the OPUS specialized early intervention trial for patients with a first episode of psychosis' *Schizophrenia Bulletin*, 41.3 (2015) 617-626.

[280] Sherry K W Chan et al, 'A systematic review of long-term outcomes of patients with psychosis who received early intervention services' *International Review of Psychiatry*, 31.5-6 (2019) 425-440, <https://doi.org/10.1080/09540261.2019.1643704> [accessed 6 July 2020],

[281] Gregory A Light and Neal R Swerdlow, 'Bending the curve on psychosis outcomes' *The Lancet Psychiatry*, 2.5 (2015), 365–367, <https://doi.org/10.1016/S2215-0366(15)00172-8> [accessed 6 July 2020]; European Society for Child and Adolescent Psychiatry, '2017 keynote – The "massive double standard" for access to mental health care, Patrick McGorry: "Early treatment is bending the curve of outcome"', <https://www.escap.eu/policy/access-to-mental-health-care/> [accessed 7 June 2020].

of functioning has been achieved on a population basis, beyond a small number of years in a sub-group of patients who have been treated in early intervention programs.

The prevalence of mental illness is not decreasing

242 Despite mental health prevention being high on Australia's mental health agendas ever since the Second Mental Health Plan (1997)[282] and the existence of important and extensive mental health initiatives such as Beyond Blue (since 2000) and headspace (since 2006), the prevalence of common mental disorders with very high symptom levels has not significantly reduced in Australia over the years.[283] Indeed, some studies have shown that the prevalence of diagnosed anxiety and depression has increased.[284]

243 In relation to serious mental illness, an authoritative review of schizophrenia epidemiology by John McGrath and his colleagues suggests that the prevalence of schizophrenia has remained stable, although its incidence may be decreasing over time.[285] The data reviewed are not consistent, with for example, an increased incidence in the UK and a decreased incidence in Finland. Longitudinal studies within specific catchment areas are required to clarify whether there is in fact a change in the incidence of the disorder. On a world population basis, the estimated number of global cases increased from more than 13 million in 1990 to almost 21 million in 2016.[286]

244 A book published in 2018 titled "The Maddest Place on Earth" by Jill Giese states that in the late 1800s, Victoria had the highest rate of "insanity" in the world; this was estimated to be 1 in 300 people.[287] Current figures indicate that there are more than 1 in 300 people in Victoria with illnesses of a similar severity as those as described in Giese's book.[288]

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[282] Department of Health, 'Second National Mental Health Plan', <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-i-midrev2-toc~mental-pubs-i-midrev2-2~mental-pubs-i-midrev2-2-sec> [accessed 29 June 2020].

[283] Samuel B Harvey et al, 'Is the prevalence of mental illness increasing in Australia? Evidence from national health surveys and administrative data, 2001–2014', *Medical Journal of Australia*, 206.11 (2017) 490-493, <https://doi.org/10.5694/mja16.00295> [accessed 3 July 2020].

[284] Anthony Jorm, 'More Australians are diagnosed with depression and anxiety but it doesn't mean mental illness is rising', *The Conversation*, 30 July 2019 <https://theconversation.com/more-australians-are-diagnosed-with-depression-and-anxiety-but-it-doesnt-mean-mental-illness-is-rising-120824> [accessed 29 June 2020]. Professor Jorm distinguishes between reported symptoms and reported diagnoses - and suggests that the former (reports of symptoms) is more valuable a measure than the latter (reports of diagnosis). I interpret this to be a reflection on the impact of over-diagnosis. Professor Jorm observes that the greatest increase in the reporting of increased diagnosis is in 15-34 year olds, especially females, and data sourced from the National Health Survey indicate a stable percentage of very high levels of symptoms of anxiety and depression from 2001 to 2017-18.

[285] John McGrath et al, 'Schizophrenia: A Concise Overview of Incidence, Prevalence, and Mortality'. *Epidemiologic Reviews,* 30.1 (2008) 67–76, <https://doi.org/10.1093/epirev/mxn001> [accessed 3 July 2020].

[286] Fiona J Charlson et al, 'Global Epidemiology and Burden of Schizophrenia: Findings From the Global Burden of Disease Study 2016', *Schizophrenia Bulletin,* 44.6 (2018) 1195 at p. 1199, <https://doi.org/10.1093/schbul/sby058> [accessed 3 July 2020].

[287] Jill Giese, 'The Maddest Place on Earth', (Australian Scholarly Publishing, 2018) at p. 59.

[288] Taking the population of Victoria in 2018 of 6.459 million (ABS, 3101.0 - Australian Demographic Statistics, Jun 2018' <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3101.0Main+Features1Jun%202018?OpenDocum

245 One of the reasons that the increase of mental health expenditure and services over the years has not been associated with a reduced prevalence of mental disorder in the community may be that those who are most in need—especially those who are experiencing serious financial hardship and those with the most significant symptoms—are not receiving the services they require. This may be because of the uneven distribution of mental health services in the community in at least two ways: first, there is a concentration of private practitioners in high socio-economic areas; and second, people with relatively mild symptoms are being treated preferentially in relation to need, in comparison to those with more severe symptoms.[289]

246 As the TAPI Submission states:

> "There is no evidence-base to direct a population-based approach to the primary prevention of many of the most serious mental illnesses – such as schizophrenia, melancholic depression, and bipolar illness. No intervention proposed to prevent the occurrence of these serious mental illnesses has passed the basic scientific test of being able to generate replicated findings. This is not to deny the value of primary prevention as a core long-term goal; but in this context it is essential that the pressing needs of people with serious mental illness are prioritised and resourced – while ongoing research seeks to better identify the causes of serious mental illnesses in order to prevent them from occurring in the first place. Until such research on primary prevention can be proven to reduce mental health service-needs, we must provision and plan our mental health system based on current demographic and population demands – and based on the principles of parity of care."[290]

247 To be clear, I am an advocate for early intervention and treatment for people with mental illness. I am also of the view that the internationally recognised early intervention programs pioneered by Professor McGorry AO and his colleagues at Orygen provide very good templates for early intervention in the non-youth segments of the Victorian mental health system. Early intervention is, of course, always preferable to late intervention. But if the latter is the only type of treatment that is possible—for example in the treatment of people whose illness has not been detected early or has been ignored, or in caring for

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ent> [accessed 15 June 2020], 1 in 300 (currently living) Victorians would be approximately the 10% most seriously ill of the 205,000 Victorians estimated to have severe mental illness in the Royal Commission Interim Report (Figure 2.1 p. 28). I acknowledge that there are methodological weaknesses in making this calculation and also in making the historical comparison, but the absence of more compelling data provides yet another reason why there needs to be a census of all people in Victoria with serious psychiatric illness as recommended in paragraph 174.

[289] Graham Meadows, Joanne Enticott and Sebastian Rosenberg, 'Three charts on: why rates of mental illness aren't going down despite higher spending', *The Conversation*, 28 June 2018 <https://theconversation.com/three-charts-on-why-rates-of-mental-illness-arent-going-down-despite-higher-spending-97534> [accessed 3 July 2020].

[290] Page vii. See further the discussion of prevention (including 'indicated prevention') in Chapter 3, pp. 29-33.

people who have ongoing and troubling symptoms—it should not be disparaged as "ambulance at the bottom of the cliff"[291] or "late intervention"[292] psychiatry.[293]

248 No matter how effective the early intervention programs of the future might be, there will always be people who need to be treated in crisis situations, or in the middle or late phase of illness, or for enduring symptoms. Early- mid- and later-stage treatment of mental illness are, and will remain, critically important elements of the Victorian mental health system. They all need to be substantially bolstered and every effort should be made to acknowledge and support the mental health professionals who provide such treatments at whatever stage of treatment they are provided.

249 In this regard, I fully agree with Professor McGorry AO and Dr Mei when they state that the "solution" "to developing adequate systems and cultures of care that effectively respond to the legitimate mental health needs of all individuals, including those presenting with less severe or early stage mental illness… is an inclusive mental health system that reduces disparities in care to ensure that all individuals experiencing mental illness or ill-health have access to high-quality and effective care at every stage of illness across the lifespan".[294]

Compulsory treatment

250 Compulsory treatment, restraint and seclusion are vexed issues.[295] Australia has a high level of compulsory treatment, and a considerably higher rate of compulsory admissions than many other countries around the world.[296] The rate of compulsory admission – which has been called "exceptionally high" by the Mental Health Tribunal[297] – was 49.7% in

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[291] The Senate, Select Committee on Health, Fourth interim report: Mental health: a consensus for action, October 2015 at p. 72.
[292] Melissa Sweet, 'Patrick McGorry defends early intervention on youth mental health', *Croakey,* 17 August 2010 <https://croakey.org/patrick-mcgorry-defends-early-intervention-on-youth-mental-health> [accessed 15 June 2020].
[293] Just as there should not be an inference that the treatment of advanced cardiac failure or advanced cancer is somehow a less enlightened form of treatment than early intervention with these disorders.
[294] Patrick D McGorry and Cristina Mei. 'Why do psychiatrists doubt the value of early intervention? The power of illusion', *Australasian Psychiatry*, 28.3 (2020) 331-334, doi:10.1177/1039856220924323, at p. 333, doi:10.1177/1039856220924323
[295] For the position of the RANZCP, see The Royal Australian & New Zealand College of Psychiatrists, Position Statement: 'Minimising the use of seclusion and restraint in people with mental illness', February 2016, <https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/minimising-the-use-of-seclusion-and-restraint-in-p> [accessed 16 June 2020].
[296] Luke Sheridan Rains et al, 'Variations in patterns of involuntary hospitalisation and in legal frameworks: an international comparative study', *The Lancet Psychiatry*, 6.5 (2019) 403-417. For completeness, I note that this paper overestimates the number of mental health beds in Australia - my colleagues and I corrected that in a Letter to the Editor.
[297] Formal submission from the Victorian Mental Health Tribunal to the Royal Commission into the Victorian Mental Health System (June 2019) (SUB.1000.0001.0979) <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/9015/6711/5782/Victorian_Mental_Health_Tribunal.pdf> [accessed 16 June 2020] at section 3.1, p. 28.

2018-19, according to Victoria's mental health services annual report of that financial year.[298]

Possible causes of the high rate of compulsory admissions

251 The causes of Australia's high rate of compulsory admissions are, of course, much more complex than the inadequate resourcing and provision of mental health services. Those causes include the fact that there is an increased rate of substance abuse within the general community, which often results in both a heightened risk of relapse and an amplification of presenting symptoms, with aggression increasingly being one of them.[299]

252 One of the best considerations for reasons of high rates of compulsory admission can be found in the Final Report of the Independent Review of the UK Mental Health Act 1983. In my view, many of the factors identified in that Report as possibly contributing to the rising levels of compulsory admission in the UK also apply to Victoria.[300] These reasons include (in addition to the previously mentioned increase in drug and alcohol use):

(a) reductions in the reach of, or quantity and quality and continuity of care (including crisis and in-home services);

(b) increased exposure to social stress stressors, including poverty and social inequality; and

(c) less continuity of care and reduced inpatient bed capacity. In relation to this contributor, the UK Final Report states: "Lack of availability of beds (evidenced by reduction in bed numbers or increased bed occupancy rates) means that patients have longer to wait for a bed and are therefore more unwell at the time of admission; or are admitted involuntarily in order to secure a bed; or are discharged prematurely and therefore more vulnerable to relapse and compulsory readmission."[301]

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[298] DHHS, 'Victoria's mental health services annual report 2018-19' <https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-annual-report> [accessed 16 June 2020] at p. 60.

[299] See for example Louisa Degenhardt, et al, 'Estimating the number of regular and dependent methamphetamine users in Australia, 2002–2014' *Medical Journal of Australia*, 204.4 (2016), 153; Foon Yin Lai et al, 'Cocaine, MDMA and methamphetamine residues in wastewater: Consumption trends (2009–2015) in South East Queensland, Australia', *Science of the Total Environment,* 568 (2016), 803-809; Louisa Degenhardt et al, 'Crystalline methamphetamine use and methamphetamine-related harms in Australia', *Drug and Alcohol Review,* 36 (2017) 160-170, <https://doi.org/10.1111/dar.12426> [accessed 3 July 2020]; Rebecca McKetin et al, 'Health service utilisation attributable to methamphetamine use in Australia: Patterns, predictors and national impact', *Drug and Alcohol Review*, 37 (2018), 196-204, <https://doi.org/10.1111/dar.12518> [accessed 3 July 2020].

[300] UK Department of Health and Social Care, 'Modernising the Mental Health Act: Increasing choice, reducing compulsion, Final report of the Independent Review of the Mental Health Act 1983', December 2018 <https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review> [accessed 25 May 2020]. See in particular Table 1, pp. 283-285.

[301] Ibid. at pp. 283-284.

Reducing the high rate of compulsory admissions

253 In my view, compulsory treatment needs to be continued, however we should be doing all that we can to reduce the high rate of compulsory treatment. There needs to be more research into how to reduce the level of compulsory treatment.

254 One way to reduce the high level of compulsory admissions is to provide an adequate level of inpatient and community care, with the former including a major bolstering of inpatient bed numbers. These measures would substantially reduce the likelihood of people becoming so unwell that involuntary care is necessary. People could be admitted because they are seriously unwell, but without necessarily being a risk to themselves or others (as in the private psychiatric hospital system).

255 This issue relates very closely to the many concerns that have been raised in relation to the assessment of psychiatric patients within Emergency Departments.[302] To some extent Emergency Departments are obliged to act as what we may call 'Mental Health Service Rationing Way Stations' – but they should do so to a much smaller extent than is currently the case. Emergency Departments are not therapeutic or 'settling' environments – they involve high sensory loads, with much activity and often considerable stress and distress. In my view, compulsory admission could occur by community mental health teams to a much greater extent – directly to mental health wards – if the beds were available.

256 Beyond patients who are being assessed for compulsory admission, the Australian private psychiatric sector provides very good illustration of the fact that Emergency Departments are being overused in the public mental health system. Private psychiatric hospitals do not have Emergency Departments – patients are directly admitted into hospital, despite the high severity of illness being treated in those hospitals.[303]

257 It is my view that Victoria should aim to be like Germany, where I understand that 85-90% of patients who require hospitalisation are admitted directly to psychiatric wards, often to disorder specific treatment wards. Compulsory admissions do occur through Emergency Departments in Germany, but my understanding is that the compulsory admission rate is around 10 to 15% - much lower than in Australia. A major contributing factor to this lower

[302] Australasian College for Emergency Medicine, 'Submission to the Royal Commission into Victoria's Mental Health System', 5 July 2019 <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/1215/6816/6071/Australasian_College_for_Emergency_Medicine.pdf> [accessed 16 June 2020].

[303] See for example Nicholas A Keks et al, 'Characteristics, diagnoses, illness course and risk profiles of inpatients admitted for at least 21 days to an Australian private psychiatric hospital' *Australasian Psychiatry*, 27.1 (2019) 25-31.

rate is the adequate provision of both inpatient and outpatient care in the mental health sector.[304]

258 It is my hope that when people look back at the current era, the very high compulsory admission rates and the overuse, with ensuing harms, of Emergency Departments as Mental Health Service Rationing Way Stations, will—by comparison to what the mental health system of the future looks like—be as antiquated as we now consider paraldehyde, chloral hydrate and potassium bromide to be as therapeutic agents in the treatment of psychiatric illness.[305]

Community treatment orders

259 The importance and value of outpatient commitment (i.e. community treatment orders) is discussed by Stephen Segal and colleagues in a series of papers published in 2017. Those papers are based on psychiatric data for thousands of patients in Victoria.[306] In one paper, the authors demonstrate that using outpatient commitment as a component of treatment orders reduces the likelihood that patients will either be victims or perpetrators of crime.[307] Another paper by Anthony Harris and colleagues from New South Wales showed that whilst community treatment orders were in place, they delayed rehospitalisation and increased community care.[308]

Compulsory treatment, human rights and conflicts of rights

260 Compulsory treatment gives rise to a conflict or tension between different rights. Specifically, the *Charter of Human Rights and Responsibilities Act 2006* (Vic) contains both a right to life (section 9) and a right to liberty (section 21).[309] Those rights are in

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[304] My evidence in this paragraph is informed by Professor Mathias Berger, ex-President of the German Psychiatric Association (DGPPN) and former Medical Director of the Department of Psychiatry and Psychotherapy at Freiburg University, Germany.

[305] Thomas A. Ban, 'Neuropsychopharmacology in Historical Perspective, Collated Bulletin 8: The Birth of Drug Industry and Drugs with An Effect On Behavior' *International Network for the History of Neuropsychopharmacology*, 2018, <http://inhn.org/home/central-office-cordoba-unit/education/thomas-a-ban-neuropsychopharmacology-in-historical-perspective-education-in-the-field-in-the-post-neuropsychopharmacology-era/collated-bulletin-8-thomas-a-ban-the-birth-of-drug-industry-and-drugs-with-an-effect-on-behavior.html> [accessed 17 June 2020].

[306] Steven P Segal, Stephania L Hayes and Lachlan Rimes, 'The utility of outpatient commitment: I. a need for treatment and a least restrictive alternative to psychiatric hospitalization' *Psychiatric Services*, 68.12 (2017), 1247-1254; Steven P Segal, Stephania L Hayes and Lachlan Rimes, 'The utility of outpatient commitment: II. Mortality risk and protecting health, safety, and quality of life' *Psychiatric Services*, 68.12 (2017), 1255-1261.

[307] Steven P Segal, Stephania L Hayes and Lachlan Rimes, 'The Utility of outpatient commitment: Reduced-risks of victimization and crime perpetration' *European Psychiatry*, 56 (2019), 97-104. The authors found (inter alia) that "CTO-assignment was associated with reduced safety-risk: 17% in initial-perpetrations,11% in initial-victimizations, and 22% for repeat-perpetrations." (at p. 97 and see further the discussion at p. 103).

[308] Anthony Harris et al, 'Community treatment orders increase community care and delay readmission while in force: Results from a large population-based study', *Australian & New Zealand Journal of Psychiatry*, 53.3. (2019), 228–235 <https://doi.org/10.1177/0004867418758920> [accessed 3 July 2020].

[309] Victorian legislation, 'Charter of Human Rights and Responsibilities Act 2006' <https://www.legislation.vic.gov.au/in-force/acts/charter-human-rights-and-responsibilities-act-2006> [accessed 16 June 2020].

tension with one another, and are also in tension with the duty of care set out in the *Wrongs Act 1958* (Vic).[310]

261 Some people argue that we should abolish compulsory admission because it breaches the UN Convention on the Rights of Persons with Disabilities. I strongly disagree with that proposition. In my view, the core reason we need to continue the use of compulsory treatment in Victoria is that we need to protect the right to life as well as the right to health.[311] Specifically, we need to protect the right to life of patients who are at a high risk for serious self-harm, including suicide, as a result of psychiatric illness and, to a lesser extent, because we need to protect against the relative frequency of serious harm to others by people with a psychiatric illness.

Duty to protect people "in real and immediate risk" of taking their own lives

262 The right to life, and the importance of a corresponding duty to protect that right, are highlighted by the case from the United Kingdom of Melanie Rabone. In 2005, Ms Rabone was a 24 year old informal (voluntary) patient in an NHS hospital. She was suicidal and had made previous suicide attempts. She wanted to go home for the weekend; her father was vehemently against it, while her mother was part of the clinical conference where it was decided Ms Rabone could go home. She went home and hanged herself. The UK Supreme Court found that even though Ms Rabone was not compulsorily detained, the NHS hospital had a duty to protect her life. This case highlights that mental health care providers have a duty to take action to prevent people in 'real and immediate risk' of taking their own lives.[312]

The liability of mental health professionals towards the victims of crimes perpetrated by their patients

263 The following two cases related to the rare phenomenon of psychiatric patients seriously harming or killing others, and the responsibility of mental health professionals to protect society from that happening. In other words, do mental health professionals owe a duty of care to potential victims of their patients, and is compulsorily admitting patients a way for mental health professionals to ensure they fulfil that duty?[313] In considering these two cases, it is important to highlight that the perpetration of homicide by people with serious

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[310] Victorian legislation, 'Wrongs Act 1958' <https://www.legislation.vic.gov.au/in-force/acts/wrongs-act-1958/127> [accessed 16 June 2020].
[311] See for example the discussion of the right to health in *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 from [93].
[312] *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2, [2012] MHLO 6.
[313] See for example the following paper which describes mental health professionals who have been found guilty of manslaughter in Italy as a result of their patients killing others: Claudio Terranova and Gabriele Rocca, 'Homicide committed by psychiatric patients: Psychiatrists' liability in Italian law cases', *Medicine, Science and the Law*, 56.1 (2016) 58-64.

mental illness is a rare event.[314] I discuss these two individual cases (one Australian and one international) because, in my view, they illustrate some of the principles that I believe are worthy of consideration, and one aspect of why compulsory treatment should be retained.

a) The Pettigrove case

264 In 2004 Mr Pettigrove was being treated in a New South Wales hospital for a psychotic disorder as an involuntary patient under the NSW Mental Health Act. The hospital discharged Mr Pettigrove to the care of a friend, Mr Rose, who was then to drive him from that hospital to Victoria for further treatment. Whilst the two friends were camping en route to Victoria, Mr Pettigrove killed Mr Rose because he believed that in a previous life Mr Rose had murdered him, and then killed himself. The relatives of Mr Rose sued the hospital for discharging Mr Pettigrove on the basis that the hospital had a duty to Mr Rose.

265 Overturning a decision made in a lower court, the NSW Court of Appeal found that, in the particular circumstances of the case, the hospital owed a duty of care to Mr Rose to prevent Mr Pettigrove causing physical harm to Mr Rose; and that the hospital's liability (and the doctor's negligence) extended to the harm caused to Mr Rose's relatives, the Plaintiffs.[315] This judgement was, however, overturned by the High Court which concluded that there was no duty of care to Mr Rose's relatives.[316]

266 This case highlights the limitations in relation to whom a common law duty of care is owed. The High Court's judgment also highlights the limitations of the statutory prohibition

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[314] According to the Australian Institute of Criminology, there were 51 homicides in Victoria in 2017-2018 (an incident rate of 0.78 per 100,000, the same as the national average): S Bricknell, 'Homicide in Australia 2017-18. Statistical Report no. 23'. *Canberra: Australian Institute of Criminology,* 2020 <https://www.aic.gov.au/publications/sr/sr23> [accessed 2 July 2020] at Tables A2 and A3. See also Queensland Government, 'When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services: Final Report', April 2016 <https://www.publications.qld.gov.au/dataset/mental-health-sentinel-events-review-2016/resource/2729969e-7e2c-403f-aef9-32002ca957ff> [accessed 2 July 2020], which highlights the rarity of homicide by people with mental illness. The Final Report states (at pp. 35-36, citations omitted): "Homicides in Australia are a relatively rare event with a rate in the national population of 1.1 per 100,000… Within the Australian rate, eight per cent (8%) or 0.09 per 100,000 are committed by a perpetrator with a known mental illness. Compared to severe mental illness occurrence of two to three per cent (2–3%) within the community, perpetrators with a mental illness are over-represented within the offender population. Research in Victoria investigating the rate of schizophrenia among people who commit homicide revealed that those with schizophrenia, who formed 0.7 per cent of the general population, were responsible for almost nine per cent (9%) of the homicides. This represents a relative risk of 13 times. Among women who commit homicide, one quarter were found to have schizophrenia." See also D J Bennett et al, 'Schizophrenia disorders, substance abuse and prior offending in a sequential series of 435 homicides' *Acta Psychiatrica Scandinavica,* 124.3 (2011) 226-233; DOI: 10.1111/j.1600-0447.2011.01731, which is the paper that reports the Victorian research on homicides committed by people with schizophrenia (and is referenced in the Queensland Final Report).

[315] *McKenna v Hunter & New England Local Health District; Simon v Hunter & New England Local Health District* [2013] NSWCA 476, available at <http://www6.austlii.edu.au/cgi-bin/viewdoc/au/cases/nsw/NSWCA/2013/476.html> [accessed 3 July 2020].

[316] *Hunter and New England Local Health District v McKenna; Hunter and New England Local Health District v Simon* [2014] HCA 44, available at <http://eresources.hcourt.gov.au/showCase/2014/HCA/44> [accessed 3 July 2020]. See the discussion of the Pettigrove case in Anthony Gray, 'The liability of providers of mental health services in negligence' *University of Western Australia Law Review*, 40 (2015) at p.164..

on detaining a person except in circumstances where no less restrictive care was appropriate and available;[317] the High Court found that performance of that obligation by the treating psychiatrist "would not be consistent with a common law duty of care requiring regard to be had to the interests of those, or some of those, with whom the mentally ill person may come in contact when not detained." (at [29]). This case made clear that various laws are in tension with one another, but, on my reading, did not clarify what if any duty of care was owed by the hospital and treating psychiatrist to the deceased.

b) The responsibility of Dr Canarelli

267 In 2012, French psychiatrist Danielle Canarelli was found guilty of involuntary homicide and given a one year suspended sentence, after one of her patients murdered his grandmother's partner. Dr Canarelli decided to not use coercive measures with the highly at-risk patient during his therapy and justified that decision by "the need to establish and maintain a trusting relationship with the patient".[318] According to a report of the case in *Psychiatric Times:* "The court did not share this reasoning and argued that while therapeutic alliance is of "major importance," the relationship of trust "is not an end in itself but only a means for patient adherence for the best outcome." [319]

Responsibility of mental health professionals when a patient is at risk of self-harm

268 If a mental health professional believes their patient with a mental illness is at very high risk for seriously harming themselves or others as a result of that illness, but the patient does not want treatment, then, under most circumstances I consider it to be a degradation of the patient's right to life to and an abrogation of the duty to protect the life of others for whom a clear threat has been posed, to not treat that patient. This issue not only arises for patients who are acutely suicidal or at risk of causing serious harm to others. For example, a patient may be seriously unwell with psychosis and delusions – not eating because they believe their food has been poisoned, and living in squalor and neglect, heading in a serious downwards spiral in poor self-care. If that patient's mental health professional does not take action to help the patient, they will in my view be depriving them of the reasonable chance of a better life with treatment.

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[317] *Mental Health Act 1990* (NSW), s 20.
[318] Carol Jonas and Nidal Nabhan Abou, 'Psychiatric liability: a French psychiatrist sentenced after a murder committed by her patient', *Psychiatric Times*, 30.4 (2013) available at <https://www.psychiatrictimes.com/forensic-psychiatry/psychiatric-liability-french-psychiatrist-sentenced-after-murder-committed-her-patient> [accessed 25 May 2020]. See also Clare Dyer, 'French psychiatrist is convicted of manslaughter after her patient kills an elderly man', *BMJ* (2012) 345:e8693, https://doi.org/10.1136/bmj.e8693; and Sara Williams, 'A dark day for psychiatry?', *Casebook* 21(2) (2013) 9-11, <https://www.medicalprotection.org/singapore/mps-casebook/casebook-may-2013/a-dark-day-for-psychiatry>.
[319] Ibid.

Responsibility of mental health professionals when a patient lacks insight

269 A significant percentage of people who have psychotic illnesses have a condition called anosognosia or lack of insight.[320] People with this condition, which may vary in intensity over time, are not aware that they are unwell and that they need treatment. Compulsory treatment may be necessary for a person with anosognosia because they may be refusing treatment without a reasonable degree of insight and awareness into their condition and the need for treatment.

The role of advance statements

270 The *Mental Health Act 2014* (Vic) promotes widespread and intensive use of advance statements. It has an emphasis on supported decision making and giving more agency to people with lived experience of mental illness. In my view, the Victorian Act is considerably more patient-centric than, for example, the equivalent Act in the UK.

271 The partnership component of advance statements is key. Advance statements mean that clinicians and patients are engaged in a discussion about treatment and future planning; they prompt a consideration of the trajectory that might occur in a patient's clinical care at various stages. However, my understanding is that advance statements tend not to be used nearly as much as they could be in Victoria.

272 In 2016, Mark de Jong and colleagues published a paper in which they examined interventions that might reduce compulsory psychiatric admission.[321] The authors conducted a meta-analysis of 13 randomised clinical trials and demonstrated that the use of advance statements was the only intervention that led to a reduction in compulsory admission. This research supports the fact that the use of advance statements might well have a positive effect in reducing the rate of compulsory admission in Victoria.

273 Building on the work of de Jong and colleagues, there needs to be significantly more research into the use of advance statements and other methods for reducing the use of compulsion within our mental health system. There also needs to be more utilisation of advance statements.

[320] Douglas S Lehrer and Jennifer Lorenz, 'Anosognosia in schizophrenia: hidden in plain sight', *Innovations in clinical neuroscience,* 11 (2014), 10-17, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4140620/pdf/icns_11_5-6_10.pdf> [accessed 16 June 2020].
[321] Mark H de Jong et al, 'Interventions to reduce compulsory psychiatric admissions: a systematic review and meta-analysis' *JAMA psychiatry*, 73.7 (2016), .657-664.

The *Mental Health Act* and the notion of 'fusion law'

274 One possible alternative to the compulsion provisions of the current Mental Health Act is to introduce what is known as 'fusion law'.[322] Fusion law incorporates the principles of: a) lack of mental capacity (decision-making capacity); and b) best interests.[323] As legislated in Northern Ireland, it fuses mental capacity law[324] with the compulsion components of the Mental Health Act.

275 Fusion law essentially argues that the Mental Health Act (as currently framed in places including Victoria and the UK) discriminates against people with mental illness because it only provides for preventive detention of people with a mental illness. For example, if a person has anti-social personality traits and is dangerous in some way, but has not committed a crime, you cannot preventatively detain them unless they have a mental illness.

276 In contrast, fusion law makes no differentiation between people with mental illness and those free from mental illness. According to a fusion law approach, if for whatever reason a person lacks capacity[325] and compulsory treatment is in their "best interests", then an order for compulsory treatment should be made, *regardless of whether that person has a mental illness*. In my view, although the introduction of such a law might be a way to reduce the rate of compulsory admission, for reasons similar to those provided by the UK Independent Review into Modernising the Mental Health Act,[326] I consider that its introduction in Victoria would be premature. The UK Independent Review provided five reasons for reaching this view, two of which are worth particular mention:

(a) first, the principle of "best interests" of the person being assessed, may, in some circumstances, result in substantial risks to others, that would not be in the public interest; and

(b) secondly, fusion law is being implemented in Northern Ireland,[327] and the consequences – both positive and negative – should be carefully assessed by other jurisdictions before the law or a modification of it should be considered.

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[322] John Dawson and George Szmukler, 'Fusion of mental health and incapacity legislation' *British Journal of Psychiatry*, 188 (2006), 504-509.
[323] George Szmukler, '"Capacity", "best interests", "will and preferences" and the UN Convention on the Rights of Persons with Disabilities', *World Psychiatry*, 18.1 (2019), 34-41.
[324] The relevant mental capacity legislation in the UK is known as the Mental Capacity Act. Our equivalent in Victoria is the *Medical Treatment Planning and Decisions* Act 2016 (Vic).
[325] By lack of capacity, I mean that a person lacks the three decision making components which are to: a) understand a decision; b) retain the information relevant to that decision to use, weigh or summons the information; and c) communicate your decision.
[326] UK Department of Health and Social Care, 'Modernising the Mental Health Act: Increasing choice, reducing compulsion, Final report of the Independent Review of the Mental Health Act 1983',December 2018 <https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review> [accessed 25 May 2020] at pp. 222-227.
[327] Northern Ireland Department of Health, 'Mental Capacity Act Background' <https://www.health-ni.gov.uk/mental-capacity-act-background> [accessed 27 June 2020].

277 That said, such a proposed reform might well be of interest for consideration by the Victorian Law Commission prior to any eventual consideration by the Victorian Government.

Factors which might enable the Royal Commission's recommendations to have an enduring effect

278 In the past 12-18 months, much has been written about how to optimise the effect of Royal Commissions, so that they endure over the long term.[328] Ensuring that the recommendations of this Royal Commission have an enduring effect is vital; we cannot afford to keep repeating the past.

A brief overview of previous Royal Commissions and other Public Inquiries

279 Over the years, there have been many Royal Commissions, Public Inquiries and reports regarding the mental health system, both in Victoria and across the country. In considering what factors might enable the current Royal Commission's recommendations to have an enduring effect, it is informative to analyse what led to the many previous Inquiries, and why many of them have *not* had enduring positive effects.

280 It is difficult to estimate the number of Royal Commissions and Inquiries that have taken place over the years. According to an article published in 2013 by Merrilyn Walton, there had been 39 inquiries into psychiatric facilities and mental health services in Australia at that time.[329]

281 The first Inquiry into mental illness (then called lunacy) in Victoria took place one year after the establishment of Victoria as a separate colony (in 1851), when a Parliamentary

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[328] See, for example the following series of articles published in *The Mandarin*: Peter Wilkins and John Phillimore, 'Royal commission recommendations: processes to ensure they are implemented', 6 February 2019, <https://www.themandarin.com.au/103724-royal-commission-recommendations-processes-to-ensure-they-are-implemented/> [accessed 25 May 2020]; Peter Wilkins and John Phillimore, 'What are the merits of royal commissions and other forms of inquiry?', 18 February 2019, <https://www.themandarin.com.au/104199-what-are-the-merits-of-royal-commissions-and-other-forms-of-inquiry/> [accessed 25 May 2020]; Peter Debus, 'Are royal commissions the new normal for developing complex public policy?', 12 June 2019, <https://www.themandarin.com.au/109874-are-royal-commissions-the-new-normal-for-developing-complex-public-policy/> [accessed 25 May 2020]. See also: Dominique Hogan-Doran SC, 'Lessons for Government from Recent Royal Commissions and Public Inquiries', paper presented to the Law Society of New South Wales Government Solicitors' Conference 2019, 3 September 2019,<https://www.vicbar.com.au/file/9646/download?token=T9bVkRTl> accessed 25 May 2020], particularly at pp.30-32.

[329] Merrilyn Walton, 'Deep sleep therapy and Chelmsford Private Hospital: have we learnt anything?' *Australian Psychiatry*, 21.3 (2013), 206-212. A copy of this article is available at <https://www.researchgate.net/publication/236968637_Deep_sleep_therapy_and_Chelmsford_Private_Hospital_have_we_learnt_anything> [accessed 25 May 2020]. In addition, a partial list of Royal Commissions and Boards of Inquiry can be found at the following Australian Psychiatric Care website: <http://www.ahpi.esrc.unimelb.edu.au/browse_royalcommissionsandboardsofinquiry.htm> [accessed 25 May 2020].

Inquiry was conducted into the Yarra Bend Lunatic Asylum (completed in 1852). The first Royal Commission into mental illness followed in 1886.[330]

The cycle of Royal Commissions and Inquiries

282 The cycle of Royal Commissions and Inquiries into the mental health system is like an incautious driver on a very long road in the outback: at the beginning, everything is going well; then hours later it starts getting dark and the driver realises that they have begun to doze, are driving off the road and are about to crash; suddenly, they get an almighty jolt! In the same way, Royal Commissions and Inquiries into the mental health system tend to happen by tumultuous jolts and crises. But eventually – some time later – often more than a decade later – just like the recurrently drowsy long-distance driver, the system "dozes off" and only gets reformed after a series of jolts, sometimes only when it has crashed, or is about to do so.

283 For example, the jolt may be the suicide of a child from the same school as the Premier's children (which was something Daniel Andrews specifically mentioned when he announced in October 2018 that the current Royal Commission would be held if Labor won the 2018 Victorian election).[331] The Victorian Auditor-General (**VAGO**) also played an important role in providing a jolt—a massive one—through its audit of access to mental health services, which found a "lack of sufficient and appropriate system-level planning, investment, and monitoring over many years".[332]

284 Back in the 1990s, former Federal Human Rights Commissioner Brian Burdekin said it was an inquiry into children's homelessness that prompted the National Inquiry into the Human Rights of People with Mental Illness.[333]

The roles of 'champions' and organisations to maintain ongoing 'stewardship' of the implementation of the recommendations of Royal Commissions and Inquiries

285 Each past Public Inquiry and Royal Commission has also had its own champion. For example, the 1886 Royal Commission was set up largely in response to agitation by the

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[330] For further information about these early Inquiries and Royal Commissions, see: C.R.D. Brothers, *Early Victorian Psychiatry*, 1835-1905, Melbourne, 1964 (see in particular at pp. 21-26 regarding the 1952 Parliamentary Inquiry, and at pp. 135-145 regarding the 1886 Royal Commission); and Richard Bonwick, Masters Research thesis: 'The history of Yarra Bend Lunatic Asylum, Melbourne' *Department of Psychiatry, University of Melbourne,* available at <https://minerva-access.unimelb.edu.au/handle/11343/38829> [accessed 6 July 2020], (see in particular at pp 31-22 regarding the 1852 Parliamentary Inquiry, and at pp 54-60 regarding the 1886 Royal Commission).

[331] ABC News, 'Victorian Premier Daniel Andrews promises royal commission into mental health', 24 October 2018, <https://www.abc.net.au/news/2018-10-24/victoria-daniel-andrews-royal-commission-into-mental-health/10423104> [accessed 7 June 2020]

[332] Victorian Auditor-General's Office, 'Access to Mental Health Services', March 2019, at p. 8, <https://www.audit.vic.gov.au/report/access-mental-health-services> [accessed 25 May 2020].

[333] Australian Human Rights Commission, 'Burdekin: National Inquiry', <https://humanrights.gov.au/about/news/speeches/burdekin-national-inquiry> [accessed 8 June 2020].

Medical Board of Victoria,[334] while Premier Daniel Andrews and Minister Foley have been the champions for the current Royal Commission.

286 Having a champion is important in establishing Royal Commissions and major Inquiries, but that person will not necessarily be in a position to champion the implementation of the recommendations. For instance, it is highly unlikely that Daniel Andrews will be the Victorian Premier, or that Minister Foley will be the Victorian Minister for Mental Health, in ten years' time. It is therefore critical that there are other mechanisms in place which can ensure that the recommendations of this Royal Commission are implemented in an effective and timely manner.

287 In the absence, over the longer term, of the 'initiating champions' of the Royal Commission, who can ensure continuity of effort and purpose in relation to implementing the Royal Commission's recommendations? One mechanism that my TAPI colleagues and I recommended is the establishment of:

> "A cross-portfolio subcommittee of Cabinet should be established to ensure that the policy recommendations from the Royal Commission are effectively introduced. This subcommittee should be shadowed by an Interdepartmental Committee (IDC) of all departmental secretaries germane to mental health. An Independent Monitoring Officer with statutory powers should be appointed to monitor the progress of the implementation of the Royal Commission's recommendations."[335]

288 I consider that these very high level committees and the Independent Monitoring Officer are likely to be able to provide effective stewardship of the implementation of the Royal Commission's recommendations over a three to five year period. However, based on my understanding that specially-purposed Cabinet subcommittees usually only operate for a small number of years, I do not think these frameworks and roles are likely to exist—or if they do, are likely to retain efficacy—beyond that time-frame. In order to ensure longer term stewardship, other solutions need to be invoked.

289 One theoretical option might be for an oversighting organisation such as VAGO to be responsible for tracking and reporting on the progress of the implementation of the Royal Commission's recommendations over, say, ten years. I have come to the conclusion that this would be inadvisable and unachievable because:

(a) VAGO is an independent entity and so neither the Royal Commission nor the government of the day could direct VAGO to undertake this role; and

[334] C.R.D. Brothers (1964), above footnote 330 at p 135.
[335] Recommendation 26. See discussion in Section 8.6, p. 88.

(b) even if it were possible to request that VAGO accepts this responsibility, each year it undertakes approximately 500 financial audits for the State Government and local councils, as well as more than 20 performance audits. As part of this role, VAGO has undertaken audits on mental health, and is almost certainly likely to continue to do so. However, VAGO does have significant capacity restraints.

290 Another option might be that a Victorian Mental Health Commission, similar to the State Government Mental Health Commissions in Queensland, New South Wales, South Australia and Western Australia could take on this stewardship role. However, as I discussed above from paragraph 191, it is my view that establishing such a Commission would involve setting up an unnecessary additional layer of bureaucracy. Furthermore although other Mental Health Commissions within Australia have policy, strategic vision and review functions (amongst others), to the best of my knowledge, they do not have the capacity to mandate ongoing reform at the highest levels of government. It is also unlikely that a newly-established Victorian Mental Health Commission would be granted any such powers.

291 Yet another possibility might be to establish a "long-life" (lasting at least ten years) special unit relating to the current Royal Commission, for example in the Department responsible for mental health. That unit could then be responsible for implementing the recommendations of this Royal Commission, and might work in conjunction with the Independent Monitoring Officer (as described in paragraph 287 above). In my view, this would not be advisable because there are other critical issues such as domestic and family violence and child sexual abuse that also need ongoing follow-through of the recently handed down recommendations of the Royal Commissions in those areas.

A specialist Royal Commissions and Major Inquiries Unit

292 Instead, I consider that a permanent Royal Commissions and Major Inquiries Unit should be established within the Victorian Department of Premier and Cabinet (**DPC**). The role of that Unit would be to:

(a) provide guidance on the establishment and running of Royal Commissions and major inquiries;

(b) serve as a repository of accumulated information and wisdom about the establishment, scope and findings of Royal Commissions and major inquiries; and

(c) most importantly, publish annual reports on the implementation of recommendations from all Victorian Royal Commissions and major inquiries for at least a decade following the conclusion of each one.

293 This proposal echoes one of the core recommendations of the UK's Institute for Government in its summary of how Public Inquiries can lead to change, where it recommended that "Government should implement the repeated recommendation of Parliament to create a permanent inquiries unit within the Cabinet Office."[336]

294 In my view, there are three potential locations within the current structure of DPC where an independent unit of this nature could be set up, namely:

(a) under the Deputy Secretary of Social Policy, noting that there is already an Executive Director of Mental Health Royal Commission Coordination who reports to the Deputy Secretary of Social Policy;

(b) under the Deputy Secretary for Services Systems Reform;[337] or

(c) separate from these organisational streams, and reporting directly to the Secretary of the Department.

Unifying advocacy for Mental Health Reform in Australia – lessons from the creation and implementation of the National Disability Insurance Scheme (NDIS)

295 In my view, the early history of NDIS can also offer a number of helpful lessons for the mental health sector. It provides a blueprint for what factors might enable the mental health sector to become more coherent, cohesive and effective.

296 In particular, the early history of the NDIS teaches us that we need:

(a) people with lived experience of the mental health system playing a key public role as advocates from the outset;

(b) recognition that we cannot expect politicians to support reforms unless there is already clear, visible and unified community support;

(c) a coordinated approach across multiple levels of government; and

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[336] Institute for Government, 'Summary: How public inquiries can lead to change', 2017, available for download at <https://www.instituteforgovernment.org.uk/summary-how-public-inquiries-can-lead-change> [accessed 7 June 2020]. One of its recommendations (which covers two of the three roles I have suggested above, see paragraphs 292(a) and (b)) is that "Government should implement the repeated recommendation of Parliament to create a permanent inquiries unit within the Cabinet Office. Its first task should be the production of more detailed – and ideally public – guidance on running inquiries. Its second task should be to act as the repository for lessons learned from previous inquiries and to work with inquiry secretariats to ensure that this duty can be discharged" (Recommendation 4). The Institute for Government "is the leading think tank [in the UK' working to make government more effective. [It provides] rigorous research and analysis, topical commentary and public events to explore the key challenges facing government... [Its] research focuses on the big governance challenges of the day and on finding new ways to help government improve, rethink and sometimes see things differently." See Institute for Government, 'About us' <https://www.instituteforgovernment.org.uk/about-us> [accessed 7 June 2020].

[337] The current high-level organisation chart for DPC is available at Victorian Government, 'DPC structure and organisational chart', <https://www.vic.gov.au/dpc-structure-organisational-chart> [accessed 8 June 2020].

(d) the mechanisms by which an outcome can be provided.[338]

297 The creation of the NDIS was made possible by a group of people with diverse experience and expertise, each with significant power and influence, *coming together*. It involved key figures such as the Reverend and Hon. Brian Howe AO, Professor Bruce Bonyhady AM, the Hon. Bill Shorten MP, the Hon. Mr John Della Bosca, Professor Rhonda Galbally AC, the Hon. Julia Gillard AC, the Hon. Jenny Macklin, and ultimately the Hon. Tony Abbott AC who committed to the NDIS in March 2013. The Productivity Commission also played an important role.[339]

298 The development of the NDIS was like an elegant chess game, with a carefully carved out strategy. Remarkably, the planning and execution of that strategy happened across only five years, between 2008 and 2013. In my view, no other sector has been able to bring key stakeholders and advocates together in the same way that the disability sector did to create the NDIS.

299 One of the keys to creating the NDIS was the formation of the National Disability and Carer Alliance. Through this Alliance, people with disabilities, their family members and their advocates met with many politicians and members of the community. This was important because it brought to light the issues facing people with disabilities and their carers.[340]

300 Similarly, in the mental health sector we need to bring together people with lived experience of mental illness and their families and carers, including through:

(a) organisations such as the Victorian Mental Illness Awareness Council (VMIAC), the National Mental Health Consumer and Carer Forum and Tandem; and

(b) mental health professional organisations such as the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Australian Psychological Society (APS) and the Australian College of Mental Health Nurses (ACMHN).

Currently, while there are some prominent advocates in the area of mental health, I consider there is insufficient broader advocacy and insufficient coordination among and between professionals, community members and politicians.

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[338] The following article published by *Inside Story* in 2013 highlights the various forces that came together to enable a dramatic transformation for disabled people in our country, through the creation of the NDIS: Mike Steketee, 'How a forty-year-old proposal became a movement for change', *Inside Story,* 22 October 2013 <https://insidestory.org.au/how-a-forty-year-old-proposal-became-a-movement-for-change/> [accessed 6 July 2020].

[339] The article referenced at footnote 338 above describes the involvement of each of these key figures.

[340] For further details about the Alliance, and the leadership of Professor Rhonda Galbally AC and the Hon. John Della Bosca in its formation, see the article referenced at footnote 338 above.

301 If we are to learn from the broad-based and fast-tracked advocacy success of the disability movement, the mental health sector needs to come together and advocate for the mental health system – Commonwealth and State – *as a whole*, rather than:

(a) having particular interest groups (including the consortium that I am associated with) advocating primarily and separately for specific sub-components of the mental health system (e.g. youth mental health,[341] adult mental health[342] and women's mental health[343]); or

(b) disparaging, for example, the hospital components of the State public mental health systems.[344]

302 We also need to be aware that a considerable component of the success of the NDIS was attributable to initiatives taken by politicians and ex-politicians. In other words, they were key "actors" and prime movers, in a manner that a number of political leaders at both the State and Commonwealth levels are currently being in relation to mental health. It is important for all of us in the mental health sector to welcome, acknowledge and applaud these efforts.

sign here ►

print name David Copolov

date 7 July 2020

[341] See for example Patrick D McGorry, Rosemary Purcell, Ian B Hickie and Anthony F Jorm, 'Investing in youth mental health is a best buy'. *Medical Journal of Australia*, 187.7 (2007), S5, <https://www.mja.com.au/journal/2007/187/7/investing-youth-mental-health-best-buy> [accessed 8 June 2020].

[342] Such as TAPI.

[343] See for example the 'Statement from the Women's Mental Health Alliance', 27 November 2019, <https://womenshealthvic.com.au/resources/WHV_Publications/Position-Paper_2019.11.27_Womens-Mental-Health-Alliance-Statement_(Fulltext).pdf> [accessed 4 July 2020]; and Australian Nursing and Midwifery Journal, 'Urgent action needed for the mental health of women and girls', 27 November 2019 <https://anmj.org.au/urgent-action-needed-for-the-mental-health-of-women-and-girls/> [accessed 8 June 2020].

[344] See for example Melissa Davey, 'Mental health funding 'locked down in dysfunctional hospital system' – Ian Hickie', *The Guardian*, 2 February 2017, <https://www.theguardian.com/society/2017/feb/02/mental-health-funding-locked-down-in-dysfunctional-hospital-system-ian-hickie> [accessed 8 June 2020].

Royal Commission into
Victoria's Mental Health System

ATTACHMENT DC-1

This is the attachment marked 'DC-1' referred to in the witness statement of David Copolov dated 7 July 2020.

CURRICULUM VITAE

Professor David Leon Copolov, AO

MB BS, PhD, DPM, MPM, FRACP, FRANZCP

July 2020

NAME:	**David Leon Copolov**
CURRENT APPOINTMENTS:	**Pro Vice-Chancellor, Major Campuses and Student Engagement, Monash University**
	Professor of Psychiatry, Monash University
	Honorary Professor of Physiology, Monash University
	Professorial Fellow with the title Professor, Department of Psychiatry, University of Melbourne
	Governor and Professorial Fellow, The Florey Institute for Neuroscience an Mental Health
	Director of the Board of Monash University Foundation
	Director of the Board of the Frankston Revitalisation (State Government)

EDUCATION (selected aspects)

Schooling:	Captain of Debating and Dux of Economics, 6th Form (1968), Scotch College, Melbourne
Undergraduate:	Bachelor of Medicine, Bachelor of Surgery The University of Melbourne (1974)
University Colleges:	Queen's College 1969-72 St Hilda's College 1973-4
Leadership:	President, Students' Club (Sports and Social Club), Queen's College (1972)

ACADEMIC ACHIEVEMENTS

in Final Year Medicine (1974)

Equal first place on Aggregate Mark List

- Equal first place: Surgery
- 1st place: Obstetrics & Gynaecology
- 2nd Class Honours: Medicine

Prizes in Final Year:

Recipient of the

- Stirling Prize for Surgery
- J.P. Ryan Prize for Surgery
- Healey Scholarship for Surgery
- Beaney Scholarship for Surgery
- Fulton Scholarship in Obstetrics
- Jacobs Prize in Clinical Gynaecology
- Mead-Johnston Prize in Paediatrics

POSTGRADUATE QUALIFICATIONS

- Diploma of Psychological Medicine, University of Melbourne, 1979
- Membership of the Royal Australian & New Zealand College of Psychiatrists, 1980
- Fellowship of the Royal Australian & New Zealand College of Psychiatrists, 1982
- Fellowship of the Royal Australasian College of Physicians, 1983
- PhD: topic - Aspects of the Measurement and Physiology of Immunoreactive Beta Endorphin, Monash University, 1983
- Master of Psychological Medicine, Monash University, 1986

SELECTED AWARDS AND RECOGNITION IN THE PAST SEVERAL YEARS

2016	Officer, Order of Australia, General Division
2013	Australian Neuroscience Legend – Florey Institute of Neuroscience and Mental Health
2011	Medal, Order of Australia, General Division
2006	Organon Senior Research Award, Royal Australian and New Zealand College of Psychiatrists
2006	Installed as a Fellow of St Hilda's College, University of Melbourne
2003	Founders' Medal of the Australian Society of Psychiatric Research
2002	Public speaking competition award for Year 7 students at Scotch College named the David Copolov Trophy
2000	Installed as a Fellow of Queen's College, University of Melbourne
2000	Community Mental Health Award - Schizophrenia Fellowship of Victoria, now named the Mental Illness Fellowship
1998 on	Entry in Who's Who

PROFESSIONAL EXPERIENCE

Current and Recent Appointments

1. **Monash University** (in addition to Professor of Psychiatry - since 1996)

2009 - ***Pro Vice-Chancellor (Major Campuses and Student Engagement)***

Responsibility for Student Engagement across three major campuses – Clayton, Caulfield and Peninsula and Student Leadership across all campuses. Responsible for the oversight of Mental Health Programs across the University.

2004 -2009 ***Senior Advisor – Office of the Vice Chancellor and President***. I played strategic and implementation roles in major cross-Faculty and cross-university initiatives in energy, water, climate change, ageing, research capability mapping, rural and regional medicine and leadership.

2. The Royal Women's Hospital

2014-2020 Director of the Board of the Royal Women's Hospital, and Chair of the Research Committee

3. Peter MacCallum Cancer Centre

2007-2013 Deputy Chairman of the Board

2006 - Chairman, Psychosocial Support Program Steering Committee

2005-2010- Chairman of the Research Advisory Committee

2004 - 2013 Director, Board of Directors

2004 - Director, Board of Management, Peter Mac Foundation and Member of Grants Allocation Committee of the Foundation

4 The Australian Nuclear Science and Technology Organisation (ANSTO)

2008 - 2016 Director

2008 - 2016 Director and Member of Audit and Cyclotron Committees

5. Governing Board, Cooperative Research Centre on Water Quality and Treatment

2004- 08 Director

6. Bio21 Australia Cluster

2008 - 2013 Director

7. Trustee position

2002 - Trustee, Finkel Philanthropic Foundation ($14 million corpus)

8. The Florey Institute of Neuroscience and Mental Health

2013- Professorial Fellow

9. Monash University Foundation

2020- Director of the Board - $480m funds under management

10. Director, Frankston Revitalisation Board (State Government)

2020 - Director of the Board - enhancing the future of Frankston region, where the Monash University Peninsula campus is located

Previous and Other Appointments

Medical and psychiatric positions held:

	1975 - 1976	Intern then Junior Resident Medical Officer, Royal Melbourne Hospital
	1977 - 1979	Psychiatric Registrar, Prince Henry's Hospital
	1980 - 1986	Liaison Psychiatrist in the Psychiatric Treatment Centre, Prince Henry's Hospital
		- Renal Unit 1980
		- Endocrine Unit 1981-86
	1982 - 1983	Fellow in Clinical Endocrinology, Prince Henry's Hospital
	1984 - 1987	Honorary Consultant, Royal Park Psychiatric Hospital
	1991 - 2004	Psychiatrist, Department of Psychiatry, Royal Melbourne Hospital
Academic positions held	1980 – 1981	Lecturer, Department of Psychological Medicine, Monash University
	1982 – 1985	Senior Lecturer, Department of Psychological Medicine, Monash University
	1985 – 1991	Associate, Department of Psychological Medicine, Monash University
	1986 – 1991	Senior Associate, Department of Psychiatry, University of Melbourne
	1991 – 1996	Associate Professor, Monash University
	1992 -	Professorial Fellow (Professor), Department of Psychiatry, University of Melbourne
	1996 - 2007	Honorary Professor of Psychiatry, Monash University
	2007-	Professor of Psychiatry, Monash University
	2007-	Honorary Professor of Physiology, Monash University
	2002 - 2007	Professorial Fellow (Professor), Centre for Neuroscience, University of Melbourne
Research-related positions held:	1984 – 1987	Director, Aubrey Lewis Clinical Research Unit, Royal Park Hospital
	1985 - 2004	**Executive Director, The Mental Health Research Institute of Victoria** – during this period I was responsible for developing the Institute from a staff of three with a non-salary operating budget of $9,000 working in a Nissen hut, to the largest psychiatric research institute in Australia with 100

		staff, a budget of $8 million per annum, state-of-the-art research facilities and substantial neuroscience research capacity.
	1988 - 1996	Co-Director, NH&MRC Schizophrenia Research Unit
	1991 – 1993	President of The Australian Society for Psychiatric Research
	1994 - 1995	Member of the Board of Research, Royal Australian & New Zealand College of Psychiatrists
	1994 – 2000	Chief Investigator NHMRC Brain Network into Mental Disorders
Board and Senior Management roles at the Mental Health Research Institute:	1987 – 2004	Member, MHRI Board
	1987 – 2004	Member, MHRI Scientific Advisory Committee
	1987 – 2004	Member, MHRI Board - Executive Committee, later (2002) called the Policy and Strategy Committee
	1989 – 2004	Member, MHRI Development Council
	1997 – 2002	Chair, MHRI Executive Committee (senior staff), subsequently named the Management Committee, MHRI
	2000 – 2004	Member, MHRI Board - Intellectual Property & Commercialisation Committee
	2003 – 2004	Member, MHRI Board - Budget and Finance Committee (first created 2003)
	2003 – 2004	Member, Senior Scientists' Council, MHRI
Advisory (to government) positions held:	1992 - 2004	Member, Ministerial Advisory Committee on Mental Health, Department of Human Services, Victoria
	1992 - 1994	Senior Policy Advisor, Office of Psychiatric Services, Health Department Victoria
	1992 - 2000	Australian Drug Evaluation Committee (as its psychiatric expert), Commonwealth Department of Health.
	1996 - 1999	Member, Cannabis and Psychosis Research Reference Group, State Government Department of Human Services
Roles played in association with the NMHRC:	1987 - 2000	Member, Regional Grants Interviewing Committee/Grant Review Panels NH&MRC
	1989 - 1995	Member, Assigners Panel, National Health and Medical Research Council
	1993 - 1994	Head of the Diagnostic Consortia of the NHMRC Network into Brain Disorders
	1999 - 2001	Member, Evidence Based Clinical Practice Research Program Committee of the National Health and Medical Research Council

Roles played within Neurosciences Victoria (NSV):	2001 - 2002	Member, Neurosciences Australia Scientific Advisory Committee
	2002 - 2004	Member, NSV Platforms Advisory Committee
	2003 - 2004	Platform Leader, NSV Clinical Neurobiology of Psychiatry
Pharmaceutical company advisory roles:	1994 - 2000	Director, Clozaril Patient Monitoring System (Clozaril is an antipsychotic drug which is used for patients who don't respond to other antipsychotics)
	1994 - 2003	Member, Clozaril Quality Assurance Committee
	2002 - 2003	Chair, Aripiprazole Steering Committee (aripiprazole is an antipsychotic drug)
Reviewer of many grants, including those from the:	▪ Wellcome Trust, UK ▪ British Academy ▪ Westmead Millennium Foundation (Westmead Hospital) ▪ Medical Research Advisory Committee, Australian Brewers' Foundation ▪ BioFirst Awards, NSW Health ▪ Israel Science Foundation	
Other Research and Advisory Activities (selected, mainly recent):	2015	Panellist on the mid-term performance review panel of the CRC for Mental Health
	1989	Member, Assessors Panel, New Zealand Medical Research Council
	1994 - 1996	Medical Advisor to Project Beacon, Victoria Police (to Assistant Commissioner Ray Shuey), on the introduction of oleoresin capsicum spray into the Police force (introduced in 1996) - This measure has dramatically reduced the number of psychiatric patients killed by the Police
	1998 - 2003	Member, Medical Advisory Panel, World Schizophrenia Fellowship
	2001 - 2003	Member, BioMelbourne Network Steering Committee
	2001 - 2004	Director, Biocomm International
	2002	External Reviewer of Professorship and Head of Department of Mental Health, University of Aberdeen, 2002
	2002 - 2004	Member, Psychiatry Victoria Steering Committee
	2002 - 2004	Chair, Lilly Melbourne Academic Psychiatry Pipeline & Enabling Technologies Domain Committee
	2002 - 2004	Member, beyondblue Policy Committee

2003 - 2004	Member, beyondblue Victorian Centre of Excellence Expert Committee
2003 - 2004	Member, Collegium Internationale Neuro-Psychopharmacologicum (CINP) International Psychopharmacology Algorithm Project (IPAP) (CINP is the leading international umbrella group within the field of the pharmacological psychiatry. Membership is by invitation)
2003 - 2004	Chair, Collegium Internationale Neuro-Psychopharmacologicum (CINP) Nominating Committee (chooses candidates for the Presidency and other Executive positions)
2002 - 2006	Member, Scientific Advisory Committee, The MIND Institute (Mental Illness and Neuroscience Discovery), USA
2003 - 2006	Member, Clinical Neuroscience Group (primarily neurologists)
2003	Invited member of Inaugural Scientific Strategic Planning Meeting to set up the Mental Health and Addiction Research Centre at Christchurch Medical School, New Zealand
2003 - 2005	Member, Myer Foundation Planning Committee of National Research Program on Psychosis
2004 - 2007	Advisor, Faculty of 1000 Medicine, Section on Schizophrenia and Other Psychoses
2004 -2006	Member of the Scientific Advisory Board, Salus Institute of Mental Health, (Magdelburg, Germany)
2004 -2006	Member of the Scientific Advisory Committee, Gold Coast Institute of Mental Health
2004 - 2010	Member of the Advisory Committee, Australian Advanced Neuroscience Research Initiative
2005	Member of Expert Panel to choose the site for the Chair in Schizophrenia Research for the Neuroscience Institute for Schizophrenia and Allied Disorders
2006 - 2010	Independent Scientist, Governance Committee of the Australian Schizophrenia Research Bank
2007 - 2016	Member of the Forensicare (Victorian Institute of Forensic Psychiatry) Medical Appointments and Credentialling Advisory Committee

Selected invited lectures/presentations:

- Invited Speaker, Nobel Symposium, 'Schizophrenia: Pathophysiological Mechanisms', Karolinska Institute, Stockholm, Sweden October 1998
- Invited Speaker, "Genes, Neurons and Mental Illness" Symposium, The Institute for Biomedical Research, University of Sydney, June 2002
- Invited Speaker, World Federation for Mental Health Biennial Congress, Melbourne, "Collaborative Partnerships: A researcher's perspective", February 2003
- Invited Speaker, The therapeutic challenges posed by schizophrenia: complex neurobiology and inadequate antipsychotic drug efficacy", CSIRO Health Science and Nutrition's 2nd Conference for the Pharmaceutical Sector, July 2003
- Invited Speaker, The Second David Serry Commemorative Lecture, Albert Road Clinic, Melbourne, October 2002
- Invited Speaker, John Curtin School of Medical Research, Canberra, October, 2002
- Invited Speaker, "Clinical Neurobiology of Psychiatry Platform", National Neuroscience Facility Launch August 2003
- Invited Speaker, Scotch College Foundation, 30th Anniversary Speech, August 2003
- Invited Speaker, Mental Illness Fellowship AGM, October 2003
- Invited Speaker, Grand Rounds, Department of Psychiatry, VA Hospital, Greater Los Angeles Healthcare System, USA, June 2005
- The Fourth Eric Osborn Oration, Queen's College, University of Melbourne (http://www.queens.unimelb.edu.au/news/01osborn.html)

Ordinary membership of Scientific Organisations:

Current

- Collegium Internationale Neuro-Psychopharmacologium

Past

- Australian Society for Psychiatric Research
- Australian Society for Medical Research
- The New York Academy of Science
- The Australian Society for Biochemistry and Molecular Biology

RESEARCH GRANTS

During my active research career I was a Chief Investigator or Co-investigator on competitive grants – including ten NH&MRC grants - which received more than $26 m.

POSTGRADUATE STUDENT SUPERVISION

Teaching Involvement

PhD Students have included:

- Jayashri Kulkarni MB BS, FRANZCP, MPM
- Nicholas Keks MBBS, FRANZCP, MPM
- Brian Dean MSc
- Joe Ciorcare MSc
- Mark Throsby BSc (Hons)
- Weiqing Huang MD
- Peter Line BAppSc, MAppSc
- Philip Marzella Grad Dip Aud, BSc(Hons)
- Marc Seal, BSc(Hons)
- Alexandra Rehn
- Mark Walterfang
- Tracey Shea
- Melissa Wright

In addition, I have undertaken the supervision of BSc(Hons), BMedSc and MSc students.

Examiner for Higher Degrees (since 2002):

- PhD Examiner for the University of Sydney, 2002
- PhD Examiner for the University of Melbourne, 2003
- BMedSci Examiner for the University of Melbourne, 2002
- DSc Examiner, University of Canterbury (NZ) 2005

Reviewer for Journals:	▪ Archives of General Psychiatry ▪ American Journal of Psychiatry ▪ Biological Psychiatry ▪ The Australian and New Zealand Journal of Psychiatry ▪ Schizophrenia Bulletin ▪ Psychoneuroendocrinology ▪ Psychiatry Research
Editorial Board Membership:	▪ Journal of Neural Transmission ▪ Psychiatry Research
Hobbies:	Singing and performing (had been under personal tuition for the 18 years), reading history and biography, tennis and recreational walking.
Publications	245 peer-reviews articles and 21 chapters / books / monographs

B. PUBLICATIONS

Papers:

1. Smith GC & Copolov D. (l979) Brain Amines & peptides - their relevance to Psychiatry, *Australian & New Zealand Journal of Psychiatry*, 13:283-29l.

2. Copolov D. & Helme R. (l983) Enkephalins and endorphins: clinical, pharmacological and therapeutic implications. *Drugs*, 26:503-519.

3. Jefferys D, Copolov D, Irby D & Funder J. (l983) Behavioural effect of adrenalectomy: reversal by glucocorticoids or D-Ala2- Met5-enkephalinamide. *Eur.J.Pharmacol*, 92:99-l03.

4. Copolov D, Jethwa J, Stern A, Clements J and Funder J. (l983) Insulin hypoglycaemia and cholinergic blockade response of immunoreactive-endorphin. *Clin.Endocrinol*, l9:575-583.

5. Hall S, Littlejohn G, Jethwa J & Copolov D. (l983) Plasma-endorphin levels in fibrositis. *Arthritis & Rheumatism*, 26:39.

6. Hulse GK, Coleman GJ, Copolov DL & Lee VWK. (l984) The effect of chronic stress on reproductive function in the white rat. *Endocrinology*, 100, 271-275.

7. Fuller P, Lim A, Barlow J, White E, Khalid B, Copolov D, Lolait S, Funder J & Stockigt J. (l984) A pituitary tumour producing high molecular weight ACTH related peptides: clinical and cell culture studies. *J.Clin.Endoc.Metab,* 58:l34-l42.

8. Smith GC & Copolov D. (l984) Physical manifestations of stress. *Patient Management*, 115-120.

9. Jefferys D, Copolov D & Funder J. (l984) Naloxone inhibits both glucocorticoid and D-Ala2-Met5-enkephalinamide reversal of the behavioural effects of adrenalectomy. *Eur.J.Pharmacol*, 103:205.

10. Copolov D. (1985) Opioid Biology - the next set of questions. *Aust.N.Z. Journal of Medicine*, 15:98-106.

11. Kulkarni J, McLachlan R & Copolov D. (l984) The medical and psychological investigation of psychogenic polydipsia: a case report. *Br.J.Psychiat*, l46:545-548.

12. Copolov D, Rubin RT, Mander AJ, Sarhidharan SP, Whitehouse AM, Blackburn I, Freeman CP, Blackwood D, Lane L & Poland RE. (l985) Pre- and Post-dexamethasone salivary cortisol concentrations in major depression. *Psychoneuroendocrinology*, 10:461-467.

13. Hulse GK, Coleman GJ, Copolov DL and Lee VWK. (1985) The role of endogenous opioid peptides in the effects of constant illumination on reproductive function in the rat. *Pharmacol. Biochem.& Behav,* 23:535-539.

14. Keks N and Copolov D. (l986) The Clinical Use of Antipsychotics. *The Australian Prescriber,* 9:79-82.

15. Keks N and Copolov D. (l986) The Optimum Use of Depot Anti-psychotics. *Current Therapeutics,* 32-43.

16. Whalley LJ, Borthwick N, Copolov D, Dick N, Christie JE and Fink G. (1986) Glucocorticoid receptors and depression. *British Medical Journal,* 292:859-861.

17. Copolov DL, Rubin RT, Mander AJ, Sashidharan SP, Whitehouse AM, Blackburn IM, Freeman CP and Blackwood DHR. (1986) DSM-III melancholia: Do the criteria reliably distinguish endogenomorphic depression? *Journal of Affective Disorders,* 10:191-202.

18. Jones KV, Copolov DL & Outch KH. (1986) Type A, test performance and salivary cortisol. *Journal of Psychosomatic Research,* 6:99-707.

19. Keks N, Copolov DL, Singh B. (1987) Abnormal prolactin response to haloperidol challenge in men with schizophrenia. *Am.J.Psychiatry,* 144:1335-1337.

20. Keks N, Copolov D, Singh B. (1987) Prolactin response to low-dose intravenous haloperidol in neuroleptic-free men with schizophrenia defined by five diagnostic systems. *Neuroendocrinology Letters,* 9:220.

21. McGorry PD, Campbell R, Copolov DL. (1987) The Zelig Phenomenon: specific form of identity disturbance. *Aust. N.Z. Journal of Psychiatry,* 21:532-538.

22. Recher H, Willis GL, Smith GC and Copolov DL. (1988) ßir-endorphin, corticosterone, cholesterol and triglyceride concentrations in rat plasma after stress, cingulotomy or both. *Pharmacology, Biochemistry and Behaviour,* 31:75-79.

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30. Keks NA, Kulkarni J, Copolov DL. (1989) Treatment of Schizophrenia. *The Medical Journal of Australia,* 151:462-467.

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32. McGorry P, Copolov D, Singh B. (1989) The Validity of the Assessment of Psychopathology of the Psychoses. *Aust. N.Z. Journal of Psychiatry,* 23:469-482.

33. Copolov DL, McGorry P, Keks N, Minas I, Herrman H, Singh B. (1989) Origins and Establishment of the Schizophrenia Research Programme at Royal Park Hospital. *Aust. N.Z. Journal of Psychiatry,* 23:443-452.

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35. Copolov D, Keks N, Kulkarni J, Singh B, McKenzie D, McGorry P and Hill C. (1990) Prolactin Response to Low-Dose haloperidol Challenge in Schizophrenic, Non-Schizophrenic Psychotic and Control Subjects. *Psychoneuroendocrinology*, 15:225-231.

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37. Dean B and Copolov D. (1990) Phorbol esters increase [^{3}H] dopamine uptake by the human platelet. *Platelets*, 1:135-137.

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39. Dean B, Srikanthan P, Copolov DL. (1990) Are there homologies between the dopamine uptake mechanism of the central nervous system and the human platelet? *European Journal of Pharmacology,* 183:403-404.

40. Lim AT, Dean B, Copolov DL. (1990) Evidence of post-translational processing of auriculin ß to atriopeptin III immediately prior to secretion by hypothalamic neurons in culture. *Endocrinology*, 127:2598-2600.

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