Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF ELIZABETH DEVENY

I, Elizabeth Deveny, Chief Executive Officer of South Eastern Melbourne Primary Health Network (**SEMPHN**), of Level 2, 15 Corporate Drive, Heatherton VIC, say as follows:

Professional background

1 I am currently the CEO of SEMPHN and have been in this position since July 2015. The SEMPHN works primarily on behalf of the Commonwealth government to improve local health care by improving existing services, commissioning new services to improve health outcomes and to encourage GPs and other medical professional to improve local health care. SEMPHN's seven key priorities are mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, digital health and aged care. The SEMPHN's catchment area is from St Kilda to Sorrento to Bunyip in Victoria. This includes the major population hubs of Clayton, Dandenong, Moorabbin, Caulfield, Cranbourne, Frankston and Pakenham.

2 Since May 2017, I have been a member of the Southern Metropolitan Partnership. This partnership is an advisory group established by the Victorian government to enable a pathway for local communities to engage with state and local governments and advise the government in relation to priorities for services, infrastructure and employment.

3 I have been a member of the Australian Digital Health Agency since May 2016, and have been the Chair of that agency since April 2019.

4 Prior to my role with the SEMPHN,

(a) I was the CEO of Bayside Medicare Local from February 2012 to June 2015;

(b) the Acting CEO of Northern Melbourne Medicare Local from September to December 2011;

(c) a coordinator of VicREN at the University of Melbourne (VicREN is a practice-based research and education network between the Department of General Practice at the University of Melbourne, primary care practices in Australia (mostly Victoria) and other researchers); and

(d) the Business Development Manager of Sovereign Health from 2007 to 2010.

5 Prior to these roles, I was a Research Fellow in the Department of Ophthalmology from 2006 to 2007 and the Department of Paediatrics from 2005 to 2007, and a Research Manager with Therapeutic Guidelines Limited form 2003 to January 2005.

6 I hold a Bachelors of Training and Development and a Master's Degree in vocational education (health education) from the University of Melbourne. I am a Doctor of Philosophy having completed my PhD in 2004 from the University of Melbourne in the Medicine faculty in relation to clinical decision making. Between 1980 and 2000, I was also a volunteer with St John Ambulance Australia from junior to senior leadership and operational roles.

7 I make this statement in my personal capacity as CEO of SEMPHN and from my own personal experience in relation to digital health. I make this statement as the representative of the SEMPHN.

8 I do not make this statement as a representative of the Commonwealth or any of its entities, including the Australian Digital Health Agency.

PANEL QUESTIONS

Question 1: In thinking about an ideal future community mental health system in Victoria, what are some of the system features, services components or supports that will be critical in effectively supporting:

a. people experiencing mild mental illness?

b. people with moderate mental illness?

c. people experiencing severe or chronic mental illness?

d. families and carers?

9 I offer a note of caution in developing a new model. When we start talking about what an ideal future model may look like in Victoria, we need to start with what an ideal national model looks like. Health is funded by state and federal governments and reforms that do not integrate models of care will inevitably further fragment the system, leading to poorer outcomes for consumers. In 2015, the National Mental Health Commission (**NMHC**) laid out a road map for improvement in mental health services, which included an ideal national model in its report: *Contributing Lives, Thriving Communities – Report of the National Review of Mental Health Programmes and Services*. Primary Health Networks (**PHNs**) were charged with undertaking that work, and it remains on-going. Given this, we have not yet determined whether the current model – supported by the federal government through funding initiatives – will meet community expectations and improved health outcomes.

10 However, before talking about whether to create yet another state-based model, we should first test the work PHNs are currently undertaking in accordance with the recommendations made by the NMHC.

11 There are three aspects of the NHMC’s national model that are worth emphasising:

(a) **Accountability and transparency** – PHNs provide an opportunity for taxpayers to have an accountable and transparent mental health spend. This is very important, and different to previous funding approaches. The community has a right to know how funds are being spent and has a right to see the outcomes that result from that expenditure. At SEMPHN, we are very focussed on ensuring that the community can see our outcomes. Of course, our outcomes represent only one part of the consumer’s journey. To understand whether the NMHC’s recommendations will change communities experience of care, all mental health services need to adopt NMHC’s guiding principles.

(b) **The change at a health system level** set out by the NHMC **is not yet finished** – Pursuant to the NMHC's road map, all PHNs, including SEMPHN were tasked with commissioning services in Victoria with a stepped model of care framework. The PHNs commissioned a range of services guided by community need and local service availability. We use population health data to see where the community needs services the most, service mapping technologies to understand where services are currently located, and we then identify areas with high need and low service availability to target our funding. However, it takes time to embed such significant change and to effectively re-orientate the system to rigorously measure clinical outcomes. Given that our funded service may only support a person on part of their mental health journey, we need to be modest about the role our services play in a person’s recovery. In addition, the mental health workforce in particular needs time to change behaviours and then to gather enough data to show with certainty what has worked and what hasn’t.

(c) **The data is rich, however, not yet strong enough to determine what is working and what is not** – SEMPHN receives data from clinicians, our providers and consumers on a daily basis and works proactively to adjust its services in response to the data, funding levels and other supports to ensure that our services respond to the dynamic health environment. Through data, we can see trends including where services are sought, what clinical problems there may be, where we need to manage workforce issues and/or where new evidence about alternate models could assist our work. External factors also impact the mental health ecosystem, and the data received. For example, new services emerge regularly (and others close). Additionally, the community’s health and wellbeing have been challenged by a range of external factors in recent months, for example, bushfires, seasonal changes and the COVID-19 pandemic. Despite these challenges, the data strongly evidences that consumer satisfaction with our programs is high, and, where baseline data exists, consumer satisfaction is higher now than it was in relation to services that existed before the PHN services were in place. The data indicates that the focus on consumer's identified goals and the joining up of models of care wherever possible is valued by consumers. Accordingly, the data is highly illustrative and encouraging that we are making inroads. However, there is still some way to go before the NMHC's roadmap is complete.

12 I also wish to highlight consumer concerns in relation to difficulties in consumer's experiencing, navigating and accessing the mental health system. I call it 'health service literacy' – people understanding which service they can attend, when and how. The more we change things – regardless of how efficacious a particular service is – the more difficult it is for consumers to actually find and use the service they need. Accordingly, changing models of care should not be undertaken lightly and not without a strong evidence base to support the desired change.

Planning and coordination

13 Currently, SEMPHN only holds part of the mental health expenditure in Victoria. The state holds most of the funding, along with the federal government and some non-government organisations (**NGOs**), which also have programs they self-fund. Accordingly, there are likely to be efficiencies gained and better outcomes if planning and coordination related to mental health was improved and streamlined.

14 Currently, mental health planning might be undertaken by local government, state government, federal government, local hospitals, NGOs and universities, without there being any mechanism to effectively join the planning between these entities. By way of example, where there is an oversupply of a certain kind of mental health service, and an undersupply of another kind of service (such as lots of telephone counselling and not enough integrated and multi-disciplinary care), integrated planning and coordination throughout the system could identify and work to resolve this, directing funding where it is most needed. If shared planning throughout the entire system was implemented, population health level outcomes could be agreed, and accountability for actions could also be better implemented. Resultant data would also allow us to learn what is working and adjust services as required to ensure optimal results.

15 Improved planning also requires a demographic analysis of an area. SEMPHN currently undertakes demographic analyses of our catchment area. From these analyses, we can make informed decisions about what kind of services are required and how much needs to be commissioned. It also ensures that our contract providers procure the services based on our specific demographic analysis per region. We then collect data to see if we got the commissioning and procurement of services correct.

16 In addition to improved and coordinated planning, greater coordination amongst PHNs and governments would also greatly improve services and outcomes. It is important that each commissioning body (PHNs, the State, NGOs) is aware of, and understands, what services and programs other bodies plan to commission, so a shared plan can be developed, to avoid duplication and gaps.

17 For instance, if SEMPHN was aware what the Victorian government was intending to commission in the area of mental health and problematic alcohol and other drug (**AOD**) use in the next 18 months, SEMPHN could ensure that our planning coordinated with this, to ensure there was not a ‘double-up’ in commissioning work or to enable resources to be pooled in some way to assist in that particularly service delivery. For SEMPHN, as a commissioner of work, following and contributing to a coordinated shared plan is critical, rather than considering a micro-level of service delivery.

18 For example, SEMPHN has undertaken a particularly successful jointly funded program with the Victorian government related to suicide prevention across 12 Victorian sites. Unfortunately, this is not the norm. Shifting funding and disrupting the norm is slow, laborious work and is not without risk. Funding cycles and procurement timelines are not aligned and so, even where there is a desire to align work, it can be very challenging.

19 An overlay that cannot be forgotten is “ownership”. Most organisations are committed to *their* missions and visions and these do not often practically align with those of other organisations. Getting funders and provider organisations to think regionally, or at a population level is challenging. Often, organisations seek to keep the resources they have and to continue to do what they have always done and think works best. Changing this mindset can be difficult but is critical to ensure greater collaboration and coordination in the delivery of services.

Implementation plan

20 Greater coordination amongst PHNs and governments would also be advantageous for the development of regional plans, setting out how services will be implemented over a period of years. These should be shared between PHNs and the State to allow for the alignment of work and to ensure accountability around deliverables and outcomes.

Funding of family-centred care

21 For consumers of mental health services in the mild, moderate and severe/chronic categories, an essential component in any ideal future state should be based around family-centred care. Most services are built solely around a consumer and we see some problems with this approach.

22 Firstly, often consumers are heavily supported by family. When I use the word ‘family’, I use it in a generic sense and define it as ‘any person who loves a person who is unwell’. Often to keep these consumers out of hospital (possibly resulting in compulsory treatment or seclusion) we need to provide support to family. However, many funding models do not allow for family support because we have a consumer centric line of funding.

23 Secondly, it is not unusual for us to hear from a family member who has a relative who is refusing to seek care. In these circumstances, the family is unable to access any services as most models only provide some family support when a consumer is engaged with it. Often people with a severe mental illness can take a long time to engage, if they do engage at all. Under the current model, when these family members are desperate for help, there are no simple ways for support to be provided.

24 headspace is an example of an organisation that provides support to family members when they have a child in their service. However, if the child will not engage in a community mental health service or with a GP or other service, headspace has limited capacity and funding to continue to support the family.

25 An additional issue is that the only kind of support funders tend to fund is very clinical in nature. Social and other care is often syphoned off into other sectors with very few services that integrate the social and the health service needs for consumers. Sometimes, a family’s issues are not clinical in nature - for example, they could be of a psycho-social or social nature. However, in such cases, we cannot provide very well for these types of needs. This is an area of great need. The provision of psycho-social supports would make an enormous difference for a consumer and their family. Keeping people out of hospital and away from seclusion starts with the family being well supported at an early stage. To provide improved, person-centred care, we need to move away from a stark focus on clinical care and also incorporate family-centred care and psycho-social supports with appropriate funding.

‘Pathways’, entry points into the mental health system and service linkages

26 Another essential component to reaching an ideal future state of service delivery is to help consumers with a mild, moderate or severe/chronic mental illness, to enter and navigate the system. For consumers, pathway and navigation into the system is very important. If a consumer needs a service, they should not need to know who funds it to find the entry point.

27 Over recent years, there has been a push about there being ‘no wrong doors’ to enter the system. However, the counterpoint to this, is that there may be 20 ‘right doors’ because everyone will say they will help you. However, behind each of the ‘right doors’ consumers may find only part of what it is that they need.

28 Accordingly, for the SEMPHN, there is a big focus on the linkages and connections between mental health services, and between mental health services and physical health services and wellbeing. We seek to avoid situations where a consumer is required to travel between services (and, the costs associated with this) and to reduce the barriers to receiving a service. We also want to ensure that one service is not adversely impacting on a consumer's behaviour in another service and ensure there is no miscommunication or different advice being provided to a consumer about their health needs. To support our consumers, we must have better connections between services. Practically, this may mean co-located services.

29 Another practical solution in respect of entry into the mental health system is for a web-catalogue of all services in Victoria to be created which could include what services are on offer, their location, their contact details, eligibility criteria, accreditation, funding structure and source, and reported consumer experiences. For example, if I need to locate a service for a primary care AOD service, there is nowhere I can see a catalogue of applicable AOD services funded in Victoria and any data around outcomes for that service. Further, if this catalogue included outcomes, research on outcomes and commentary by clinicians, it would be useful from a coordination point of view for other services and medical providers. This would aid my organisation, for example, in considering opportunities for commissioning and partnerships.

30 For example, consider an e-commerce website where you can search for a product and it brings up the product, reviews of the product, and associated products. No such service exists in health services. There is also no way for multiple intakes to be run. In our catchment, SEMPHN runs an intake, the State runs several intakes both through hospitals and community services, and NGOs run their own intakes. For family members, you may have a family member that lives in Warrnambool and in order to find services, you may have to contact multiple organisations and hope that someone answers the phone, knows what services exist and whether they are available. This also assumes that the consumer has the money and time to make calls, can speak English and, if it is a family member, is in a position to advocate for their relative in need of a service.

Continuity of consumer health information and care

31 Continuity of a person's health information and the care they receive are essential. Our current model unfortunately tends to fragment care. It is not one clinician helping someone or coordinating care, but it is a range of clinicians offering services across a range of locations using different means of care (it may be virtual, face-to-face and/or group care) without a central coordination point. The 'My Health Record' program is an example of a program that could help ensure that anyone seeing a consumer had a way of seeing a consumer's recent health experiences as well as sharing their clinical management with whoever next sees the consumer.

32 Continuity in a person’s health information (one story that the consumer and their practitioners can understand) is crucial to the provision of quality care that meets a consumer’s interrelated needs. Additionally, having continuity of health information will prevent the need for people to tell their stories and possible traumatic events multiple times in the assessment phase.

Quality assurance in relation to care:

33 At SEMPHN, our focus is to commission great primary care mental health services and to focus on providing those services to marginalised people within our area who would not otherwise have received treatment from a service. As such, one of the areas that we focus on with our providers is that we want a percentage of their consumers to be people who have never received mental health services before. We are trying to get providers to actively seek those people through assertive outreach into the community, community development or other activities, or engagement mechanisms with local communities to engage people who are not usually users of services. So rather than just seeing people who ‘come through our door’, we are asking our service providers to look for the people who need these services.

‘Moving through’ the mental health system:

34 An ideal future state would also ensure that consumers actually ‘move through’ the mental health system. It is important that consumers do not get effectively trapped in one part of a service and that room is made for the next cohort of people to access the treatment at that particular service level. For example, for people experiencing acute or chronic mental illness, we want to avoid a situation where they continue to be an inpatient, even after their acute needs have subsided, because there is no community mental health service for them to be discharged into. This must, of course, consider that every person’s experience of treatment will be different and that for some people a long period of treatment is more appropriate. Other people’s recovery may be short. For that reason, we must avoid a situation where a person is ‘rushed’ into a service system. We need, where we can, to move people towards recovery. In some cases, that means helping them move from one particular model of care, onto another, and helping them to lead an independent and fulfilling live. To date, our system has not done this at all as well as it could have.

Addressing stigma:

35 Finally, a future ideal state must address the issue of stigma around those who experience mental illness, particularly with people who have a dual diagnosis with AOD use. Around 80% of our AOD consumers have a dual diagnosis relating to mental illness, so destigmatising these consumers is essential. SEMPHN provides a lot of programs where we offer mental health and AOD services concurrently.

36 As a cultural phenomenon, our society almost accepts stigma as being acceptable, but considers that discrimination is problematic and illegal. Society does not seem to consider that a consequence of stigmatising a cross-section of our community can lead to unlawful discrimination. A language change by governments and the media is necessary to change this stigma, as is calling out this negative behaviour as discrimination.

37 Our society has come a long way in addressing the stigma related to mental health and suicide and more recently the conversation about family violence has also advanced significantly, however, for there to be social acceptance around issues of AOD use, substantial work is required. For example, it would be helpful if the media moved away from names such as 'junkies' and 'addicts'. The consequence of the over-use of these terms in the media is that people may refuse to seek help and families may not see AOD use as a disease, but rather as a potential moral failing of their child or family unit. In turn, this can lead to a consumer experiencing shame. In the last five years, we have begun to better understand the impact of shame on health seeking behaviours, wellbeing and social isolation. Seeking a shift in the language used in relation to those managing AOD issues is an important step in moving from blame and shame to a more supportive system of care.

38 We are also learning that shame can drive family violence in a way we did not understand before, so we now need to understand how shame is driving potentially destructive behaviours and slowing recovery. Part of this work could be done through a public education campaign, given the success achieved in health campaigns related to tobacco smoking and self-harm and suicide.

39 Changing public opinion is partly about having people who have had these issues being willing to be open and talk about them. Further, to change language, we must provide individual family support and education. Consider, for example, the great success of the 'Life be in it' campaign of the 1980s and the water saving campaigns of the 2000s in terms of public education. Such campaigns have changed people's thinking. We have started to change the community's thinking about mental health, family violence and suicide but we have not yet started the conversation about AOD – the consequence being poorer uptake of services in this important area.

40 Further, AOD workers report being socially ridiculed or excluded because of their discipline. Many in society appear to consider people with AOD issues as "hopeless" and unable to be helped because addiction is their own choice. This, of course, is not true and there is much work to be done to overcome the stigma and educate the community on this issue.

Question 2: At a system level, what strategies can be employed to achieve the right balance between early access to mental health assessment and treatment; and managing the demand for mental health services?

41 I consider a stepped model of care assists in achieving the right balance in relation to early access to, and managing demand on, mental health services. This may mean that a person who is slightly unwell may come into our model of care and may only require a 'light touch' in terms of our services. But then, other difficult or traumatic events may occur in that person's life, and they may become more unwell. If a person is at one our services that offer a stepped level of care, they can see a provider who can assess them as more unwell and they can be seamlessly moved up the chain in relation to the level of care they require. That service level may increase if further traumatic events occur, or when things settle, they can move back down to a lesser level of service.

42 A stepped model of care also ensures that if a person requires a higher level of service, there is no delay in their first appointment or their initial assessment, because they are already a consumer of a service and they can be moved up and down depending on the severity of the illness or demands at a point in time. This also means that we should be able to move a person out of a service, where appropriate. Hospitals have long noted the difficulty with discharging some mental health consumers because there is "nothing" to discharge them to. However, if there is a stepped model of care, and a person is well enough to be discharged, the next model of care is available for the person to utilise, and then the next model and so on until the person is back to feeling stable.

Question 3: Commissioning strategies from Victorian and Australian Governments have progressively sought consortia models to procure the scope of services required in complex human service programs. Given your collective experience across a range of sectors (Health Services, Community Health, PHN, private hospitals), can you please outline the strengths and weaknesses of consortia as a commissioning approach?

43 SEMPHN does not commission consortia. I am aware that this type commissioning is done but I cannot comment on it in any detail because we do not commission in this way. We commission members of our organisation or commission an agency that takes on a lead role and subcontracts some of their work (but this is not a major part of our work). We mostly commission one organisation, which may subcontract some work.

44 I understand that several years ago, the state government recommissioned AOD related services in Victoria because there was a reduction in these types of providers overall. Smaller AOD organisations then banded together into a consortia model in the hope that it would keep them afloat in order to tender for State government contracts. I understand

that many AOD services in Victoria are contracted based on the consortia model. At the end of the day, as a fund-holder, I need to understand who is responsible in this model and whether it acquits what is required.

Question 4: What do you think are the most significant issues facing community mental health workforces?

45 There are an insufficient number of addiction medicine specialists in community mental health services in Victoria. This is for a range of reasons including the fact that unfortunately, a doctor can bill more as a GP than as an addiction medicine specialist. There are issues related to not only the size of the workforce in this area, but also the credentialing. There are no national standards of accreditation for AOD professionals and there is no career ladder. For example, a nurse can become a clinical nursing specialist but there is nothing like that in AOD services. AOD organisations are often tiny with very limited resources. Oftentimes, staff have worked in these services for a long time and have learnt on the job.

46 While I appreciate lived experience in a professional setting, it may also mean that a person's practice may be informed by things that might be challenged in a structured educational environment. For example, a staff member may try a management technique and it not be successful. Without sufficient foundational knowledge and appropriately qualified supervisors, workers may form views about the efficacy of treatments based on n=1 experiences. This is not ideal for staff, nor consumers. Educational opportunities for AOD staff are limited which is very problematic, both at the entry level and ongoing professional development. There are no university courses in relation to AOD, no mentoring, salaries are poor, and there are few workforce opportunities. While there is significant work to be done here to improve AOD work and outcomes, there appears little appetite to fund it.

Question 5: The Commission's interim report anticipates that '[a] contemporary workforce will be required to work in a diverse range of settings, with a greater emphasis on online services'. What is needed to help build and develop a workforce that meets these requirements?

47 To build and develop a workforce, we should review what is working well locally and encourage those local models to grow and prosper and share this working model with other services. There is a lot of capacity in the system. More junior staff ought to be mentored. There are people who have a great deal of experience who have left the profession who could return and offer mentorship if they received appropriate remuneration and other incentives.

48 We have professionalised nursing and ambulance services over the past 20-30 years. On that basis, I consider we can professionalise parts of the workforce such as AOD and can move from experience-based certificates to university degrees. Some level of generalised information about mental health and AOD issues must also be taught in medical studies. Currently students can finish a degree with virtually no exposure to these issues. To ensure better health outcomes, this should be changed.

49 I also consider it very important to implement communities of practice in the workforce. At SEMPHN, we run communities of practice. We bring practitioners together to share and learn from one another and they find it incredibly useful. Communities of practice are informed both by local need and on evidence and enable peers to learn from each other and challenge unhelpful practices. This kind of community of practice can also be modified to be based on the needs of a local community and offer local solutions.

50 Digital enhancements also need to be implemented in the mental health sector with the workforce being technically trained to offer digital health services. The need for digital health services from the consumer side is likely to be led by the younger generation. For adolescents and young adults, their entry into seeking mental health services are likely to be via a screen on a mobile phone. So, offering text services, and then upgrading to video conferencing or a group chat and ultimately building up to a face to face meeting for this cohort is the way they will likely seek services. Younger people may wish to have a consultation with a health professional virtually in a meeting room at work. However, people who are later in their life may prefer a telephone call or home visit and/ or may wish to be offered digital options also.

51 Workforce development is critically important, particularly leveraging off what we already know works through research and experience. Technology may assist in providing improved in-house training opportunities to staff or providing information, or an opportunity, for staff to communicate (for example, a Yammer or Workplace account). Communities of practice may be another option. I suspect for different communities of practitioners, how they obtain new information may be different. They might be multi-disciplinary in nature or could be thematic (for example, a group in relation to family violence).

Question 6: The service model used in Trieste in Italy appears to adopt a unique approach to the delivery of mental health services and a unique service

configuration. Based on the information the panel has received about the Trieste model:

a. ***to what extent do you think this model could be successfully implemented in Victoria?***

b. ***do you consider there are any cultural, contextual or setting differences between Trieste and Victoria that could limit the application of the Trieste model in Victoria?***

c. ***what are other examples of unique community mental health models in other jurisdictions that are having a positive impact on consumer outcomes?***

  i. ***What are their key features?***

52 In my view, the Trieste model, which dates back to the 1970s, and focuses on services where people can support you and you can stay the night when required, has some limited merit. While this model might work for some consumers, for others the option to sleep away from work and family, or to stay for a time in a somewhat institutionalised environment, may not be suitable nor promote recovery. We know that sometimes when people are admitted to hospital or attend residential rehabilitation and are taken away from their social circumstances they can stabilise and experience some recovery. Whether there is any benefit to such short-term options (whether hospital admissions or options such as in Trieste) is questionable. In some cases, these experiences do not lead to lasting change. Often once a person is back in their usual environment and facing the same challenges, they become unwell again.

53 It is important to understand that successful overseas programs do not always translate into success here in Victoria. For example, the National Health Service in the UK has been commissioning and procuring in primary health for some time. One of the reasons PHNs are doing the type of commissioning and procurement work they do, is based on the UK's example. However, in the UK, GPs are salaried and in Australia, a PHN is a fee-for-service model. This means that some of UK service models around commissioning do not work here. So, even a model where there are similar demographics, a similar cultural background, an identical language and doctors with similar training, does not necessarily mean the model will translate as successfully in Victoria.

54 It is clinical thinking to consider that a set of guidelines can just be applied anywhere. In medicine, we understand that evidence-based medicine is the conscientious and judicious application of evidence. However, this does not mean that evidence can be blindly applied to any consumer. You consider the evidence and how it would work for a particular consumer. We know that people will, for example, tailor their advice to a

consumer based on whether a consumer can afford to pay for things. There is no point telling a consumer to do something they cannot afford to do. Equally, advising a person with arthritis to go for a daily walk is unlikely to be useful so, instead, you advise them to do exercises at home or go to a hydrotherapy pool. We constantly need to look at the evidence and apply it to the context, and that is also true when applying a model of care such as the Trieste model.

COMMISSIONING

Commissioning of mental health services by SEMPHN

55 The SEMPHN commissions services locally on the base of need. Commissioning starts with identifying there is a local need for a service through population health and other data analysis. For example, based on SEMPHN's calculations, about 3% of people in our catchment have severe mental illnesses, however, only about half of them seek services. We then consider potential issues driving service use – for example, do people not seek our services because they are managing with private health services? Is it because they are sleeping rough and getting no services at all? Is it because they do not consider they have a diagnosable mental health problem because their entire family has the same illness? Is it because the person is in a family violence situation and seeking help for a mental illness is not as high a priority?

56 We then look at what services already exist to meet people's needs. At SEMPHN, we regularly layer maps to indicate our commissioning needs. We may first have a map showing population density, then we layer that with a map of service availability, then layer that with a map of hospital admissions, then layer that with a map depicting the numbers of people with psychological distress which comes from data we have collected. After we have layered these maps, we look for the areas where there are clear instances where need is high and service availability is low. We do this because we have a very small amount of funding and our aim is to meet the needs of the most marginalised. We look for the places where it is hard to get services and where we know the service need will be high. On that basis, we develop specifications, we procure a service and then we contract manage a service, evaluate a service and then we either recommission, decommission or vary the service.

57 Along this process, we attempt to obtain as much evidence as possible from everyone we can. We start with what we think the outcome should look like and these form the outcome frameworks built into our specifications. We use these outcome frameworks to build data collection instruments and evaluation plans. So, from the beginning, we know what we are working towards. We have a clear idea of what good outcomes look like and then we ensure the data that comes in from each of those programs starts to tell us whether we are meeting our objectives or not.

58 When we start our programs, we consider issues of capacity. Based on population, we expect to see a certain number of consumers and provide money and a funding formula. However, SEMPHN has 12 priority populations. These include people who live in poverty, people who are subjected to family violence, people with AOD problems, older people, CALD communities and people who are homeless. Then we look at the population health analysis of a particular local government area because we commission by local government areas to ascertain need. For example, in Port Phillip, we see a need for services directed to people who are homeless or are at risk of homelessness. In the Mornington Peninsula area, we have an older population and see a need for health services for that population.

59 In our commissioning requirements, we ask services to see a certain percentage of consumers from these marginalised communities so we can ensure we are reaching these consumers that are high risk, high need and have had low accessibility to services before our services commenced. Initially our aim was to see a 50:50 split of consumers (i.e. services saw 50% of consumers from these more marginalised groups and 50% of other consumers), however, the aim is to eventually get to an 80:20 split, where 80% of consumers are from more marginalised communities from the 12 priority areas. This is critical to ensure that we are really reaching those consumers and they are receiving much needed services.

The challenges and opportunities for SEMPHN operating as a regional commission organisation

60 The challenges in operating a regional commissioning organisation relate to aligning funding to need. In my view, the mental health system could better use the resources already in the system before we seek additional funding. As indicated, the system currently does not know what service offerings it has and who needs them. There would be great benefit in reorganising current mental health services, measuring return on investment and establishing a clear understanding as to whether current services provide good value.

61 When SEMPHN evaluated the services in place, we found that not all services were good value. Where we found this, we closed the service or changed it. Other parts of the system do not necessarily work in the same way. For this reason, it would be helpful if there was greater transparency and data was readily available, for example by being published electronically on a website. While respecting privacy requirements, the data should be able to indicate how many services there are in an area, how much unmet need there is and what is the need and how are publicly funded consumers progressing and the like. If there are services who are constantly breaching contracts and never meeting their targets, then accountability demands that the public have the right to know.

62 In terms of accountability of SEMPHN's commissioning services, we collect data from our service providers but then give it back to them. Many of our service heroes have been providing data to whoever funds them for decades but have never actually seen what the data means. At SEMPHN, we show our services their performance as compared to their peers. This has enhanced the quality of our services and our value for service because no service wants to be at the bottom of the list. This also provides tangible examples of what services are doing well and what can be adjusted and improved. We indicate to a service what they are doing and identify the things they are doing well and not doing well. We then say in a few months we are going to show you this data again, and we are going to fund you based on the fact that you actually do what we are funding you to do. That is not how other services get funded; deliverables being met in a timely way.

SEMPHN's work with hospitals in its catchment area to deliver on the commitments in the Fifth National Mental Health and Suicide Prevention Plan

63 The SEMPHN has a regional planning steering group which includes executive membership from three public hospitals (The Alfred Hospital, Peninsula Health and Monash Health). Together, we have:

(a) a commitment to broadly aligning the Fifth National Mental Health and Suicide Prevention Plan to six joint priority areas in our combined regions; and

(b) priorities for improving physical wellbeing, ensuring a systematic and coordinated approach to managing suicide prevention and improving governance arrangements in terms of partnership agreements and information sharing.

64 The aim is to ensure that we undertake operations as well as possible. We have also tried to undertake some small projects around data linkages between these hospitals in some areas, which has been useful. The SEMPHN is also independently working with Monash Health around suicide prevention. These successes have enabled SEMPHN to start to undertake local planning with hospitals and jointly work towards improving services.

65 In relation to suicide prevention, we know from the research that people who have recently been admitted to a hospital with suicidal ideation are at high risk in the next few weeks after their discharge. There is a lot of conversation about people going to hospital and then being discharged, with no care arrangements in place. A person's treating GP may not even be made aware that the person was admitted or discharged into hospital following a deterioration in that person's mental health. SEMPHN is working with Monash Health on a non-clinical program where, after a person who has a history of suicidal ideation is discharged from hospital, a non-clinician contacts that person every day for the next few months and attempts to help a person access services or with daily living skills. They may help a person make appointments, for example, with Centrelink or the

GP. This program has had strong results. This program took quite some time to negotiate because it is a non-clinical program. In primary care, we are comfortable with non-clinical options and social prescribing (for example, a GP telling a consumer that to improve their health they should go on a walk). A hospital's position is more clinical, for example, telling a consumer to take certain medication. This project took a while to establish but is now operational and while it may seem like a small project, we consider it a big win because having set this project up once, other hospitals may be more willing to roll out the same project or we could build more projects with Monash Health. In my view we have been able to engage a hospital around suicide prevention because we did the work with DHHS (referred to in paragraph 18) which gives credibility to our ideas.

Opportunities for integration between primary and specialist care, flexible funding trials and lessons learnt from the Health Care Home trials

66 The lessons learned from the Health Care Home trials is that flexibility is critical, as is a shared understanding of flexibility. For example, if the SEMPHN is given an outcome by government, the SEMPHN considers it should be able to achieve the outcome in the manner it sees fit, provided it is safe and high-quality. If our data showed that we could make the biggest change to our communities' health by, for example, recommending that people ride bikes and to eat more fruit, then we should be able to spend our funding on buying bikes and fruit. However, we may not be allowed to buy bikes pursuant to the model we are given. Another example is that a GP may prescribe attendance at a walking group made up of other consumers, a practice nurse or a dietician, however funding is unlikely to be permitted for the nurse or dietician. In practice, there is little flexibility, which can limit successful outcomes.

67 Under these models, what can be funded is a clinical model of care often attached with lengthy and prescriptive guidelines. The flexibility on offer is limited to whether, for example, a GP, mental health nurse or social worker can offer the clinical service. However, the level of flexibility sought is to be given an outcome, to be held absolutely accountable to that outcome and then to deliver the outcome using the expertise of my colleagues, including clinical and non-clinical staff. Flexibility is not choosing Model A or Model B or being able to choose the suburb I deliver a model in; flexibility is outcome based.

68 In relation to the Health Care Home trial, it is an example where the trial became very inflexible about who could be enrolled in the trial and who could not be. Small businesses with psychologists, social workers and GPs find it difficult to make a change in the model of care if they can only offer a service to a small cohort of consumers. It is far easier if they can offer the care to everyone, so let these small businesses have that flexibility.

69 Ultimately, the question should be about whether the consumer is getting good quality care and an assessment of the clinical outcomes. If these are positive, then that should be considered a demonstrable success. What should not be occurring is asking why a nurse was used here and why a psychologist was not used there. Ultimately, it is about whether the treatment models are working, whether they are clinically sound and whether there is good governance and good outcomes for consumers.

Reducing the fragmentation that exists as a result of separate Commonwealth and state funding

70 I refer to paragraphs 13 to 17 in relation to this heading. Fundamentally, I consider shared planning is essential in reducing fragmentation. Coordination and a shared alignment of activities, goals and shared data are also key in reducing fragmentation. In relation to data, SEMPHN sometimes finds that our data analysis is more detailed than state governments because we are not trying to analyse a whole state. We data collect at the granular level and know our data really well.

71 The mental health and AOD sectors have a tendency to think in ‘widgets’, and this is reinforced by current funding models. The AOD sector talks of ‘drug treatment activity units’ and in mental health, we talk about ‘sessions’. There needs to be a focus away from the funding of these ‘units’ and ‘sessions’ in a ‘bean counter way’ in order to consider the outcomes we are trying to achieve. This is because if all the money must be allocated to clinical service, how is funding in relation to workforce development allocated, or warm referrals, or clinical education and clinical governance?

72 A good start would be to fund services well, make sure that everyone understands what their role is, have strong governance in place and a shared plan. This would be a good basis from which to start to reduce the fragmentation. While the funding is poor, some services donate money for work to be done around ‘joining the dots’. When there is no clear plan of how the dots come together, consumers who sit between hospitals and GPs can fall between the gaps. Some people’s disease will be such that they will be escalated into acute care and then may be placed back into primary care or need more than ordinary primary care.

73 There is significant room for improvement in the area of clinical handover as services or as individuals. My experience is that where consumers are placed on waiting list for a new service, the previous services tends to ‘wipe their hands clean’ and not continue service offerings for these consumers, irrespective of the fact that the consumer is not yet in a new service. Once a person is moved onto another service, the first service tends to think I do not need to provide a service to them anymore and I do not need to check in because they are not my consumer anymore. There is no clinical governance around who is responsible for the health and welfare of that person until further service engagement.

The risk for that person is really high, particularly if they are very unwell and they may disengage with services altogether.

74 This issue of clinical handover is a gap and is unfunded. At the very least, additional discharge planning from hospitals is necessary so a person can be connected into a primary service before discharge to allow for some continuity in treatment. An example of this is a suicide prevention joint project called 'Way Back' undertaken by SEMPHN with various hospitals. Under the program, when someone is discharged, they are connected into a service and checks are made to ensure they are connected into a service.

SERVICE LEVEL GOVERNANCE AND PERFORMANCE MONITORING

The governance relationship between primary health networks and the Commonwealth government in the provision of mental health services

75 The Commonwealth government contracts SEMPHN. Our funding is straightforward and not complicated. It utilises a standard funding deed that provides us with information about what we are to fund. Normally, these funding deeds are very thorough and include detailed guidelines about how we are to fund services. We are required to report to government in relation to quality planning, clinical governance and financials. We are required to provide various declarations about monitoring our performance, how we acquit funds and what data we collect to ensure that we show government we are doing what we are meant to do.

76 The benefits of having a program like this is that, theoretically, we should have similar programs running all around the country. This means we should be able to provide a level of continuity when our consumers move between places. For example, as consumers move around there should be programs for people with AOD problems, people with suicide ideation, and moderate mental issues. There will be some regional variation, but this is to be expected and is a good thing. For example, some programs in remote areas might be done virtually and some programs may be run in another language depending on more localised need.

77 The challenges of the relationship centre around change management. The SEMPHN often works to improve services and offer quality improvement. That always requires change management - not just from the SEMPHN but from services generally who are funded to deliver services. However, there is no funding offered for capacity building, workforce development or change management, yet this is critical to ensure that services continue to improve and the workforce develops.

Ideal performance accountability mechanisms for commissioned mental health services

78 The accountability mechanisms in relation to oversight for mental health services commissioned by a PHN should ideally include outcome measurement. Accountability mechanisms around standard outcome compliance and financial acquittals are necessary. However, these outcomes need to be assessed over a period of time because it takes time to identify clinical outcomes and collecting data in relation to mental health is complex. For example, people may access services over 6 to 10 sessions and generally people are assessed at the beginning and end of these sessions. But a person may not complete all their sessions and leave midway through, so we never get to do a final episode test to see if their mental health has improved. In the data, it will indicate that we do not know why the person left. This means we require a point where we can say that we have considered enough completed episodes to start reviewing the data and to understand what bias there may be in the non-completed episodes.

79 We also need to ascertain the amount of work to find these consumers and see if there is any way we can find out why they left the program. However, people are not funded for this level of work. So, in relation to data, it gets complicated because we are funding services to deliver a service and to capture data but often that data is difficult to capture. For example, an AOD consumer may have four different phones and they may not have come to their last two appointments because they felt they were doing better, yet a service has no way to know if they are still feeling well or if something drastic has happened or whether they may have moved interstate.

Key incentives for collaborative work

80 In addition to strong leadership, the key to bringing people from multiple places together to collaborate and making a difference is to fund them appropriately. Generally speaking, organisations and staff in the mental health sector are financially stretched, so having enough funding for them to offer services sustainably is the key incentive in relation to collaborative work.

81 Funding a service sustainably means that it must also have funding to invest in its staff, to be able to give incentives to staff, to train them and to be able to do things such as bring in international experts if required. For example, if staff are dealing with a cohort of very young asylum seeker children and refugee children dealing with high levels of post-traumatic stress disorder because of what they have seen in their home country (as has happened in our catchment area), then we may not know how to treat these children and the consequences of what they have viewed. The ability to bring in international clinicians to provide expertise and upskill staff who are desperate to help these children would be valuable.

STEPPED CARE MODEL

An overview of SEMPHN's stepped care model

82 SEMPHN's stepped care model was built through consultations with consumers, families/carers and clinicians. Our stepped care model has six principles: – it is person-centred (and also includes a person's family), effective (and evidence based), flexible, timely, efficient and coordinated. Our funded services firstly identify a consumer's needs and goals, create a treatment plan and then coordinate any further referrals for a consumer. It is our goal for a consumer and their family to have a clear view of what a service can deliver to them so we can manage expectations and focus everybody on a shared, effective goal.

83 We only fund services that are evidence based. We also want our services to be flexible as possible, for example they may need to be available out of hours, have different locations, be co-located with specific services or have virtual options. Asking our consumers what flexibility looks like for them and comparing that to the working needs of our clinicians is key to providing this flexibility. For example, if a consumer wants services by Skype on Saturday nights it may be difficult to have clinicians to deliver those services, although, perhaps a clinician would work at that time. We have a cyber-clinic, which is a secure video channel that our clinicians can use because some of our consumers will prefer services being delivered digitally. We want our services to be efficient, so they do not waste anyone's time and to ensure good faith from a government perspective.

84 We also want our services to be timely and offer services when needed. We do not operate on a model that when a consumer's funding has run out after a certain number of sessions that they are no longer eligible for services. Our services are built on the premise that consumer needs will vary, and that they need what they need. SEMPHN provides our services with a certain amount of funding to see a set number of consumers for that amount. The service then determines what a consumer may need. For example, some consumers may need two sessions and be prescribed a walking group which will require limited funding (say $1000). However, other consumers may be more complex and require wraparound care, for example, 20 sessions of psychology, a session with a psychiatrist for a diagnosis and require a significant level of funding (say $4000). Our services can offer this and can also offer rolling funding. Additionally, sometimes our consumers may feel better in some years than others but cannot roll over funding from previous years when they required less services. This is not the case at our services. Some consumers will need a light touch and some people will require a heavy touch but we rely on the expertise of the service providers to make the call about the level of treatment required and to come back to SEMPHN if they require more funding and coordination. We offer individual referral lines and families can refer for help and ring for our services. Even if a person is ineligible for a service, we can arrange the next part of

service delivery such as a person accessing their GP or a hospital as gatekeepers of other services.

The integration of AOD and mental health supports in SEMPHN's stepped care model

85 In relation to integrated care for an AOD/mental health dual diagnosis consumer, it is not a requirement of our program that a person be sober. If someone requires dual care at a service commissioned by SEMPHN, they can ring our services and we will assess them and whether they need to go into an AOD program, a mental health program or both. This assessment depends on the consumer's needs remembering that some of our commissioned service providers are set up to take consumers who have a dual diagnosis.

86 In our severe mental health models, we have a team-based approach where we will have someone with mental health expertise, as well as someone with AOD or social work experience (or whatever is required). The person will have a lead worker working with a range of other workers who can work with the person on particular issues. We have a great primary care intensive program that works with people with substance use disorders called 'Reset Life' which has mental health, AOD and other services including family education and family therapy. It is a holistic program. This means that a consumer's mental health and AOD needs can be met in one program, rather than two separate programs.

87 However, not every program will be beneficial for all consumers. For example, you may have a consumer who is relatively stable, has employment and can work with people. But you may also have a person whose disease is so severe and may have severe behavioural issues, such that they cannot work with a group of people. They may need a more individualistic treatment plan with more clinical services such as, cognitive behavioural therapy or dialectical behavioural therapy. These people will be referred to a different type of program. A consumer with a substance use disorder and a personality episode may be referred to another type of program or need to work with a number of clinicians in two different programs. But as much as possible, we try and fund programs that do not require people to be in two different programs.

88 I do not have examples of where someone's mental health needs are low and their AOD needs are high, but this would be difficult because our programs are for more moderate to severe dual diagnosis. However, we commonly find that when you address one issue for a dual diagnosis consumer, the other issue may abate. Sometimes it is about deciding what a person's primary and immediate issue is and managing the first problem before we help with the second problem because there is a relationship between them.

Opportunities for better integration in a stepped care model

89 In order to better integrate multiple services into a stepped care model, we must first ensure that services are provided with sufficient funding to offer this model of care. For example, most services are not funded to make warm referrals so the form of these warm referrals can vary. It may mean that a service makes an appointment for a consumer with another service over the phone, or that a service provides a cab charge for the consumer to attend another service, or a staff member of the service attending an appointment with a consumer at another service, or a consumer may be able to go to an appointment on their own as long as you text them the details and arrange what they need to get there and support around it. In any of these options, the service is bearing the costs but generally the funding is skewed to offer clinical interventions only.

90 This element of what we call “brokerage” in our programs, gives service providers enough flexibility to make little payments such as a tram ticket, lunch, childcare or other incidental costs to help consumers get where they need to go. However, service providers do not have money for this generally and cannot help their consumers who are not engaging because of these incidental supports. I have known service providers to hand over their own money to consumers, which while caring, is unfair.

PSYCHOSOCIAL SUPPORTS

SEMPHN and its management of the tender process for the National Psychosocial Support Measure and the Continuity of Support Programs

91 In 2018, the SEMPHN performed a psycho-social needs assessment of the mental health and wellbeing of our community and identified the problem areas to determine the scope of service offerings. We knew we had a certain amount of money and we knew how many consumers we could see based on that funding. As such, we did a piece of work to decide who were the most marginalised consumers. We assessed what services already existed, did not exist or needed bolstering. We conducted stakeholder engagement forums and performed a range of scoping exercises where we learnt that, for example, across metropolitan Melbourne there were 70-80 services providers. The PHN then conducted a forum to co-design the solutions in terms of service provision with the actual service providers and then developed the model. We used the same sort of principles to conduct this as discussed at paragraph 82 in relation to stepped care model: – person centred, timely, flexible, and coordination. However, we also wanted to ensure services did not just focus on clinical support but also provided supported personal recovery, psycho-social supports and trauma informed approaches to care and supported consumer choice and individualised care. We then commissioned services based on our assessments and co-designed models.

92 At the time, we conducted this assessment and created our model, it was a particularly challenging exercise, because at the same time, the State government was undertaking

the same piece of work but was not in a position to share it with the SEMPHN. This meant that whilst SEMPHN had half the pool of funding for mental health in the area, we had no information about what the State government, the other funder, would be resourcing for mental health in the area. In terms of planning and coordination, this was not ideal.

93 Our 2018 exercise now means that our service offering incudes psycho-social supported, group-based interventions, individual psychological or psycho-psychological intervention programs, outreach programs and special psycho-social intervention groups into hard to reach and marginalised communities. We are also able to provide support in relation to the coordination and navigation of services so we can assist our consumers to access the correct services for their needs, which may include family support, psycho-social supports and brokerage funding. We have also ensured that where people may be eligible for NDIS funding that they be assessed for entry into the scheme, so we are not cutting across possible service offerings. We continually assess our service offerings and consumer outcomes using a range of skill assessment tools (Life Skills Profiles 16, the Kessler K-10).

94 The strength of this approach was that it was co-designed with service providers. We must have consumer-focussed principles, service design and delivery to ensure services meet consumer expectations. I consider that this co-designed approach best achieved consumer expectations. For example, some consumers felt they were getting as good a service, or even a better service, than they would get under the NDIS. This meant that some people did not want to test for the NDIS because they liked our programs. This was not the intent, as wherever possible, we want people to be supported by the NDIS. However, it indicated some frustrations with the NDIS and mental health services.

95 Some of the limitations we experienced were in relation to employing and retaining the right workforce, including peer workers. Because there were new models of funding coming into place for services and funding ending, there was a period of change management and a period of difficult transition. This meant that staff were not sure if they should stay and a lot of staff left the services. Some of the services were also not where they needed to be and struggled with how to make their programs recurrent and more future focussed. These services are being encouraged to start with data collection about the needs of their consumers and with stakeholder engagement and to reconsider their program offerings. These services also require good probity, procurement, data analysis and evaluation to keep driving improvement. This is no different to how we manage any other program.

Changes to ensure the equitable provision of psychosocial supports across the community

96 The reasons why people fail to access services are complex. Social factors, geography, language skills and more, determine whether consumers are able to navigate their way to a service. Service offerings are then limited by funding and service resources so even when you get there you may not get what you need while another person finds the offerings perfect for them. Psychosocial needs are a particularly individual construct and trying to meet these through a range of more generalised programs is challenging. Bespoke programs are generally unlikely to be commercially viable. Many programs have eligibility criteria which do not allow you to access a service if you are already receiving another kind of service, even though each service offers a different array of options for clients. These criteria are no doubt used as a rationing measure, however; their use has consequences for consumers. Allowing consumers the ability to gather all the ingredients (services) for the recipe that they need for recovery would be a great step forward.

97 To resolve inequities, a good place to start would be resolving issues around access, as mentioned above. A population health analysis that considers the demographic spread of psychosocial support service need overlaid with service availability and consumer engagement would allow us to all see maldistribution and access issues in a way that would allow a shared understanding, based in evidence, to be the foundation for change.

DIGITAL AND INFORMATION TECHNOLOGY

Opportunities for digital technology to support a new mental health system

98 In my view, the health sector does not leverage off simple digital solutions as well as many other sectors. For example, we can look at the success of banking apps as compared to what is offered in health. The biggest opportunity in my view is to leverage from simple solutions such as ‘My Health Record’ (the national health record), Skype or WhatsApp to offer internet-based options of care.

99 My Health Record is an example of a digital solution that could be very useful because it holds a summary of everything that has happened in a person’s life that can be taken to multiple different hospitals, interstate or overseas. This summary is an easy way for someone to understand what medications you are on, your previous history of trauma, your diagnosis, the names and people that have treated and helped you before and what treatment they have offered.

100 In my view, digital technologies and e-records in relation to a person’s care are necessary when a consumer of mental health services may move from an inpatient stay in hospital to a GP and to other community service providers. Having one source of readily accessible information about a consumer is very important particularly in relation to

stepped models of care and the main game, which is keeping people well and out of hospital.

101 There could be simple and easy kinds of wins in the health digital space and putting these in place would be very helpful to the sector. For example, with coronavirus, we now have a phone line for people to call. However, we should not be in position for people to have to be seriously unwell or dying before we decide to provide these options for tele or digital heath.

102 Before we invest in designing new apps or digital solutions, we should consider what existing technologies could make a difference in the mental health sector and could be leveraged. Ultimately, the interaction between the consumer and a staff-member at a service, and the improvement in the consumer's wellbeing is critical. How, where and when, the consumer accesses the service is a secondary consideration, which digital options can assist with.

103 Digital technologies could also assist the mental health workforce. Once we move into the digital space, our workforce could effectively be located anywhere. For example, at SEMPHN, we have limited workforce availability in the outer parts of our catchment area. Digital services could mean, for example, that our inner suburb workforces could remotely offer services to those outer regions, for example through cyber-clinics. However, our service funding and current models do not necessarily allow for this level of flexibility or for the purchasing of necessary equipment (it cannot be assumed that currently all staff have laptops or tablets with cameras and microphones).

104 Our workforce will also likely require training and support in being able to use digital technologies and navigate apps as many of our staff may not be digital natives. We would also want to avoid developing new digital solutions if there are ones that are fit-for purpose that already exist in the market.

105 The quality and efficacy of health and well-being apps requires further consideration. For example, our workforce may prescribe to people who have more mild or moderate mental illnesses, the use of a meditation or wellbeing app. However, there is currently little assessment of such apps, or what the best e-solutions are for particular needs (for example, apps, web pages, webinars, blogs, SMS systems, bots and avatars etc). The content of these e-solutions also require assessment as they may not contain material that is evidence-based. This is of concern because, for example, if a clinician were to prescribe a new medication, we require very substantial research about that medication, its pharmacology and in what form it should be use (a pill, a lotion etc) but the same considerations are not yet in place for current digital solutions that are being prescribed to treat mental health issues.

106 I also am aware that some clinicians are not comfortable referring people to certain digital health solutions because they do not know if the content of the app is evidence based and there is concern about any potential adverse health outcome from its use. Accordingly, further research is essential in order to gain an evidence base around these digital solutions and to be able to assess what kind of digital intervention is best. I consider this further research about digital options could be relatively easy because they could be built into some of the digital applications and ask questions from consumers about what worked and what did not.

Examples of digital technology improving mental health systems

107 We have conducted a small project in our area, which was built in the NHS, called 'Nellie' which we consider has been a positive example of a digital solution improving mental health systems for a small cohort of consumers. Nellie sends text messages to consumers based on an algorithm. We may use Nellie for consumers who may have high levels of anxiety and need a prompt to remember to use their coping mechanisms. For example, a consumer may say that patting their dog, exercising or performing breathing exercises calms down their anxiety. We can then program these ideas into Nellie and it will text the consumer and remind them to calm down using one of their coping mechanisms (for example 'go pat the dog'). Another example is for a person with depression who may struggle to leave bed in the morning. Nellie can be programmed to say 'good morning, how are you? Let me know when you are out of bed' and then the person is required to text Nellie when they get out of bed. Nellie may then prompt the person to respond once they have brushed their teeth and so on.

108 We have seen some remarkable improvements for a very small group of consumers who have responded very well to these text message prompts because it feels like a personal message to them. Nellie also enables a clinician to look at the database to make sure that people are texting back and to set up any red flags for people who are not responding via text. This allows for a clinician to get in contact with a consumer and offer any treatment (including stepped up treatment) to a person so they do not fall between the cracks. Nellie is an example of a very simple piece of technology that has some real opportunity to benefit some consumers.

THE IMPACT OF COVID-19

109 The complexity of presentations to our services has significantly increased over the past 12 weeks based on COVID-19. The need for psychosocial support, family violence support and AOD support has also increased. Many consumers no longer have a safe space as they are 'stuck' in lockdown in less than ideal situations.

110 The changed economic situation for many also means that many more consumers need financial support for things like medication supply, transport, phone credit and other consumables. Most mental health and AOD programs are not set up with brokerage funds as such and so there is quite limited funding within the system to help with these new needs.

111 Some consumers are enjoying the use of digital technologies to mediate clinical sessions, while others have expressed dissatisfaction with the loss of face-to-face sessions. Clinical governance issues in relation to this change in the mode of service delivery are still to be worked through and currently services are carrying a higher risk profile both because of the changed mode of delivery and the increased complexity of presentations.

112 I consider there is an opportunity to look to the better integration of digital and face to face modalities of care in these domains, given both the long term impact of COVID-19 on service delivery and the acceptance of the change to service modalities by many consumers.

sign here ►

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