WITNESS STATEMENT OF DR GERARD MICHAEL NAUGHTIN

I, Dr Gerard Michael Naughtin, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. The opinions that I have set out in the statement are my own and should not be taken to reflect the opinions or views of either my past or current employers. Where I make statements based on information provided by others, I believe such information to be true.

Background and experience

2 I am a qualified social worker. I have a Bachelor of Arts from Monash University (1977), a Bachelor of Social Work Monash University (1979) and a PhD from Melbourne University (2008). The topic of my thesis was "Regulating the risks of elder abuse in Australia: The Changing Nature of Government Responses.

3 I have 38 years of experience in a range of settings, including disability, aged care and mental health, and have experience working in the public, commercial and non-government sectors.

4 Between 2008 and 2017, I was the CEO of MIND Australia. I was also one of the three community mental health experts on the Federal Government's Expert Advisory Panel for the development of the National Mental Health Service Planning Framework. Attached to this statement and marked **GMN-1** are further details of my professional experience.

Please describe your current role and responsibilities

5 I am the Strategic Advisor of Mental Health within the Strategic Advice, Research and Inclusion Division at the National Disability Insurance Agency (**NDIA**). I have held this position since 14 February 2018.

6 In this position, I provide strategic advice to senior management, the NDIA Board and internal organisational groups on design and strategic policy matters in regard to mental health and psychosocial disability in the National Disability Insurance Scheme (**NDIS**).

7 As part of my role, I chair the National Mental Health Sector Reference Group which is a national advisory group which includes representatives from the major stakeholder groups involved with mental health and the NDIA.

8 I am responsible for liaising with key consumer, family and carer and service provider groups for the NDIA on mental health including Mental Health Australia (**MHA**), National

Mental Health Commission, Community Mental Health Australia, State Community Mental Health Industry Associations, Carers Australia, Mental Health Carers Australia and Mental Health Principals Committee. Part of my role is to listen to concerns and issues from these stakeholder groups, collate, report and build them into policy deliberations at different levels within the Agency. I am a Member of the Senior Officers Working Group – Mental Health, which is a sub-group to the Senior Officers Working Group of the Disability Reform Council.

9 I am the principal policy advisor to the NDIA/MHA Working Group, which includes representation from the Independent Advisory Committee and officers from the operations group within the Agency. I also participate in another working group looking at improving family and carer responsiveness for families of participants with psychosocial disability in the Scheme. This working group involves the three national mental health family and carer peak organisations, Mental Health Carers Australia, Carers Australia and Private Mental Health Consumers and Carers Network. Both groups are currently working on the formulation of recommendations to the Agency on ways to improve the experience of the NDIS for participants with psychosocial disability and their families and carers. Both working groups are due to report back to the NDIA by the end of August 2019.

Prioritisation

When is mental health prioritised by governments (at both state and federal level) relative to other service delivery and policy areas (both within the healthcare system and generally)?

10 When I reflect back on the history of the development of community mental health services in Victoria, it is a history of innovation and prioritisation of mental health service sector reform. Victoria was one of the first States to close its stand-alone psychiatric hospitals. The architecture of the current service system was established in the late 1980's and built on a service model that perceived the system transitioning from standalone psychiatric hospitals to a system of community based services, delivering State-wide geographic coverage of an integrated suite of hospital and community based services. This model envisioned the contribution of the non-government sector to the provision of community supports and drove the development of mental health community support services as they have now been come to be known in Victoria.

11 Since the 1990s, there have been a range of innovations and attempts at service system improvement with notable examples being the focus on public sector clinical services and NGO partnerships in the 2000s, the roll out of the Government Prevention and Recovery Centres (**PARCs**) and youth PARCs, provision of housing and supports through the Adult residential rehabilitation program and the introduction of recovery as a service

philosophy. In 2014, Department of Health and Human Services (**DHHS**) implemented another phase of reform of community mental health services with a significant re-tendering of services. This reform was one of the less successful reform priorities in my judgement but was intended to increase personalisation and the focus on recovery.

12 The Commonwealth Government's prioritisation and focus on mental health commenced a bit later than Victoria's but it has demonstrated a strong history on investing in mental health initiatives in response to emerging community needs. The Howard Government expanded its role in investing in mental health, in my view, in response particularly from representations from women that the burdens on families of people with mental health issues were too great and that better daily living and clinical support services were required. This lead to a period of prioritisation and investment by Commonwealth Governments since then through its community mental health program involving the funding of a national network of community mental health programs and the Personal Helpers and Mentors program, Partners in Recovery and Day to Day Living.

13 The Commonwealth Department of Health (**DoH**) has played a strong leadership role in mental health provision and innovation over the past decade. Examples of this are changes to the Medical Benefits Schedule and the funding of mental health plans and ten sessions of allied health services, the establishment of the National Mental Health Commission in 2012 to stimulate a better understanding of the policy, funding and inter-governmental co-operation arrangements for mental health, the development of five national mental health plans since 1993 and the recent focus on suicide and suicide prevention. Headspace and the role of Primary Health Networks are other examples of prioritisation. A recent example of joint governmental prioritisation of mental health is the Commonwealth and Victorian Governments' agreement to include people with a disability that is attributable to a psychiatric condition into the NDIS and delivering a generationally significant increase in daily living supports for this population group. This scheme is delivering the largest increase in funding for this group of Victorians in the history of this state with funding for this group anticipated to at least double the historical base at full scheme maturity.

14 There is no doubt about Governments' priority of mental health. A key question from my perspective is the adequacy of its prioritisation in response to the scale of the problem and its social and economic impacts on Victorian and Australian society.

Is mental health under-prioritised relative to other service delivery and policy areas? If so, why?

15 In my view, mental health is under-prioritised in political and funding processes relative to other service delivery and policy areas for a range of reasons. First, there are diverse views about priorities for change and Governments at times find the politics of change

difficult to manage. The stakeholder groups can present different and at times competing priorities to Governments at national and Victorian levels. Second, there are not as many votes in mental health reform as there are in reforms in areas such as cancer and heart disease and mental health at times struggles against other competing demands for government resources. A third factor is that the mental health service system is a very complex one with significant roles played by public and private agencies and a significant role played by several large private corporations and then thousands of small businesses through the roles played by general practitioners, psychiatrists and allied health professionals. In addition, there is a significant NGO sector that has also has its own set of interests. A key factor is that system wide change is difficult to achieve and takes a number of years, certainly longer than one electoral cycle. A fourth factor for State governments, in my view, is that they focus understandably on their priorities which are public hospital mental health services, corrections, justice, and policing. They have less focus and capacity to influence the provision of primary mental health services, which are driven by the Commonwealth predominantly through the DoH. It is hard for the States and Territory governments to get a whole of State picture of what's happening given the many elements of the system, let alone influence policy levers that are out of their control. International experience also indicates that reform is hard and the community pressures and political and bureaucratic variables need to be aligned to achieve significant change.

16 Another factor in regard to under-prioritisation, in my view, is that there has historically been a lack of awareness of the economic significance of not addressing mental health issues. Mental Health Australia and KPMG have in recent years produced a number of reports on this issue and the Commonwealth Government's brief to the Productivity Commission on the economic implications of mental health are welcome signs of possible change.

17 Finally, the lack of research funding and a more penetrating analysis of available hospital and community data and projected impacts of proposed system reform initiatives is a contributing factor when mental health proposals are competing with other significant initiatives for health reform dollars.

What are the challenges or barriers that governments otherwise face in prioritising mental health?

18 There are many challenges and opportunities that governments face in addressing improvements for mental health services. I highlight my top seven.

(a) There is a need to build a contemporary and evidence-based picture of the current elements of the mental health system in Victoria across the Victorian and Commonwealth government programs, because from my observations, current analyses are limited.

(b) Consider the new policy and funding options that are available to the Victorian Government and scope the projected outcomes for people with mental health and the service delivery system for each of these options, in coming to judgements about preferred directions moving forward.

(c) Consider the potential structural inefficiencies of the current features of the Victorian Government responses and current expenditures on mental health in this state and the ways in which existing expenditures could be used more effectively. For example, the percentage of police and ambulance resources used in addressing non-critical activities.

(d) A focus on acute end services and a failure to appreciate the importance of self-care, informal support networks and the benefits of recovery-orientated practice for all levels of mental health support services. That is, the need for a stronger focus on the full spectrum of drivers of mental ill-health and the full range of support responses. The real demands of acute and crisis care can block out a consideration of the requirements of a broader whole of community, whole of mental health system response.

(e) The need by Governments for greater recognition and dialogue in relation to the important role that employers and workplaces play in creating poor mental health through work pressures and bullying and discriminatory practices and in providing supports to workers in better management of periods of acute mental illness and in staying mentally well. An area of opportunity for the Commission is what it might consider recommending to Government about how it can use its existing relationships with industry to facilitate improved mental well-being through practices in workplaces.

(f) Continue to work collaboratively with the NDIA in implementing the NDIS for Victorians and in particular consider how we can build a smoother approach for participants between the clinical and NDIS supports.

(g) Recommend ways to address the challenges in building the workforce to address the requirements of a contemporary mental health system for the 2020's.

To what extent can Victoria influence Commonwealth policy that affects mental health outcomes in Victoria?

19 This is a difficult question to answer because of the range of policy and funding arrangements that the Commonwealth and Victorian Governments have and how they influence health, economic and social outcomes for people with mental health issues in Victoria. I am not privy to detailed negotiations and discussions so others are better informed than I to comment on this question.

20 The following are insights that I offer from my observations and experience. Mental health outcomes are reflected in many Commonwealth State agreements including health financing arrangements, the bi-lateral agreement of the NDIS, Commonwealth and Victorian agreements in regard to social housing policy, homelessness policy and agreements under the Fifth National Mental Health Plan. Many of the existing policy and funding agreements have a broader community need focus than a specific focus on mental health. Linking the specific mental health needs of the population with broader social needs is a complex process and may require deliberate focus and participation of officers with mental health knowledge when such agreements are negotiated.

21 Secondly, a significant part of system is driven by the Commonwealth and by the private sector. These are levels that the state does not necessarily control. The important questions are: what are the levers that State can pull? What are the levers it can influence?

22 There are a number of established mechanisms that could continue to be used which enable Victoria to influence Commonwealth policy on mental health: Victoria's membership of the Disability Reform Council, the Mental Health Principals Committee and its relationship to the Council of Australian Governments (**COAG**), and Victoria's membership of the Australian Health Minister's Advisory Council. Victoria can also influence the Commonwealth through the DHHS' working relationships with primary health networks.

System design

How should the mental health system be designed?

23 From my perspective, there is a threshold judgement in responding to this question. This is, what is the existing service model, are the elements and balance of this model right and appropriate? When I contrast my understanding of the current Victorian and Commonwealth service models with the international framework proposed by the World Health organisation in their document *Improving Health Systems and Services for Mental Health* (2009), the current Victorian approach has many of the elements of this internationally accepted model. Weaker areas appear to me to be self-care and recovery, prevention, early intervention and employment services. The issue is how the Victorian system can improve in these areas. If so, is it a matter of more funding and some new elements of the historical model or a fundamental re-design that seeks to respond to current and future demand? In my view, the mental health system is too heavily predicated on acute level clinical care. A key question is how to determine what the mix of clinical care and psychosocial care should be.

24 When thinking about possible system changes during the course of my role at Mind and more recently, I continue to go back to the system design that has been undertaken in

Trieste in Northern Italy by the provincial government of that region. The approach to mental health system design and the philosophy of system care grew out of their closure of a large 1,200 bed psychiatric hospital and the focus and adaptions they have made since then to continue to evolve a community based system that is world leading. Reports suggest that what is truly impressive about this mental health system is its focus on the needs of the whole person and not just clinical presentations, the availability of community based services and centres 24/7 and the reductions in the numbers of in-patient psychiatric beds that it is achieving. This service system may be of interest to the Commission to explore.

25 One of the important features of the Trieste system is that it is premised on a belief that the philosophy of care is more important than any specific services or programs that the mental health system offers. This mental health system includes a strong focus on education and employment. The approach is relational rather than clinical presentation driven and needs are assessed on the basis of personal story/history, which also addresses social relations from family to community. In order to meet the needs of mental health service users, personal relations between care workers and service users are considered central. Services are evaluated in terms of personal routes to recovery and empowerment rather than clinical indicators. Care is offered by as well as in the community, is outreaching, proactive and accessible. The approach emphasises individual control over one’s own route to recovery (Trimbos, 2012).

The National Disability Insurance Agency and the National Disability Insurance Scheme

What is the intention behind the NDIS?

26 The NDIS is a fundamental shift in the way disability supports are provided for Australians who have a significant and permanent disability and represents a once-in-a-generation social and economic reform. Its focus on improved outcomes will positively impact the lives of hundreds of thousands of participants and their families and carers.

27 Participant choice and control are core features of the NDIS’s design. In this new market-based system, participants work closely with staff to determine a plan that focuses on the specific goals they wish to achieve. In this way, NDIS participants are empowered to own their goals and aspirations and to have a say in how they attain improved social and economic outcomes.

28 The NDIS is founded on insurance principles. It is based on an insurance approach of early investment, with the objective of building individual capacity in participants to live independent lives in inclusive communities, making it a NDIS for all Australians. Australians share the risk and the cost of disability services and supports. This insurance approach is underpinned by three principles:

(a) focus on lifetime value for NDIS participants;

(b) invest in research and encourage innovation; and

(c) support the development of community capability and social capital.

29 The NDIS forms an important part of the Commonwealth Government's *National Disability Strategy 2010–2020*, a 10-year policy framework for improving life for Australians with disability, their families and carers. The strategy supports Australia's commitments to the United Nations Convention on the Rights of Persons with Disabilities. It guides public policy across all levels of government and drives change in mainstream and specialist disability programs and services, and community infrastructure. The specialist disability supports that the NDIS funds complement the mainstream services that the Australian and state and territory governments provide such as health, education, housing, transport and safety. The NDIS is delivering the largest increase in psychosocial supports in Australian and Victorian history.

What are the respective roles of the NDIS and the Victorian Government in relation to the NDIS?

30 On 27 November 2015, the Commonwealth, State and Territory governments agreed to *Principles to determine the Responsibilities of the NDIS and other service systems.* This agreement specifies that the health system will be responsible for treatment of mental illness including inpatient, ambulatory, rehabilitation/recovery and early intervention and residential care where the primary purpose is for time-limited follow-up linked to treatment of hospital diversion.

31 The NDIS will be responsible for on-going psychosocial recovery supports that focus on a person's functional ability, including those that enable a person with a severe mental illness to undertake activities of daily living and participate in the community and in social and economic life. The agreement specifies that the NDIS and the mental health system will work closely together at the local level to plan and co-ordinate streamlined care for individuals requiring both mental health and disability services. The agreement recognises that both inputs may be required at the same time and that there is need to ensure a smooth transition from one to the other.

32 DHHS, Department of Social Services, Department of Health and the NDIA have all put enormous effort in managing this transition as have many State agencies, non-government and private organisations. As at 31 March 2019, there were 7,908 active participants with approved plans in Victoria with a primary psychosocial disability.

33 There is a continuing focus by the Agency on assessment of access requests and approving first and subsequent plans.

34 The Commonwealth and Victorian governments' roles and responsibilities are clearly identified in the Applied Principles and Table of Support (APTOS) which can be provided to the Commission.

What is some of the work that the NDIA is undertaking to improve the NDIS?

35 The NDIA is undertaking work to improve the participant experience of the NDIS and one of the priority areas identified by NDIA Board and management has been improving the experience for participants with psychosocial disability. The NDIA funded Mental Health Australia (**MHA**) to provide a report on its interpretation of the feedback from a national consultation the Agency conducted on pathway improvement. MHA presented a report with 29 recommendations to the NDIA on these consultations and its views of the key issues that needed to be addressed. The former Minister for Social Services committed the Commonwealth Government to working with key stakeholders through MHA the national mental health peak organisation. Two working groups have been established. The first, the NDIA/MHA Working Group, includes representation from MHA, DSS, DoH and the NDIA and is addressing recommendations 1 to 9 and 11 to 29 of the MHA Report. The second Working Group is addressing recommendation 10 of the MHA which relates to family and carer issues. This Working Group includes representation from Mental Health Carers Australia, Carers Australia and the Private Mental Health Consumer Carers Network. Both of these Working Groups are scheduled to report to the NDIA by the end of August 2019.

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print name Gerard Michael Naughtin

Date 24 July 2019

ATTACHMENT GMN-1

This is the attachment marked 'GN-1' referred to in the witness statement of Dr Gerard Michael Naughtin dated 23 July 2019.

My professional experience in the mental health, disability and aged care sectors includes:

1 In 1989 I was awarded a Churchill Fellowship to research quality of care systems for older people and people with a disability in residential and community programs in United States, United Kingdom and Scandinavia.

2 I commenced employment as a social worker in the Victorian Department of Health in 1980, working with people with intellectual disabilities, and then shifted to employment in local government, working as the Manager of Community Services in the City of Williamstown and the Shire of Sherbrooke.

3 In 1985 I was appointed to the role of Principal Researcher and Executive Officer to the Ministerial Review into Special Accommodation Houses. This was a government review of a form of supported housing, which is now termed supported residential facilities in Victoria. As Principal researcher for the Ministerial Review into Special Accommodation Houses, I participated in extensive community consultations on standards of residential care across Victoria and drafted the Interim and Final reports of the Ministerial Review Committee, which formed the basis of legislative and regulatory change for these facilities. Supported accommodation houses accommodated many people with mental health conditions, many of who had been placed in these facilities from Victorian mental health institutions. This experience provided me with significant knowledge of the manner in which people with severe and persistent mental health were treated at that time and the systems of Victorian Government regulation. Due to my age and this early career experience, I have had the opportunity to observe patterns of clinical and community support for people with severe mental health issues over a thirty year period.

4 In 1987 I was appointed to the position of Manager Services for Older People in the Victorian Health Department and had program responsibility for a range of aged care programs including Geriatric Centres, district nursing services, geriatric assessment teams and the Standards Monitoring Division (Residential Care) of the Department. I developed a well-grounded understanding of aged care through work research and policy development work for the residential care section of the Health Act 1988, membership of the inaugural Palliative Care Advisory Council. I was a member of the HACC Joint Officers' Committee that oversaw the Home and Community Care Program in Victoria and a member of the then Commonwealth\State Government Residential Care Planning Committee.

5 My employment at the Department of Health was at the time in which deinstitutionalisation was commencing. I was involved in the decommissioning of Willsmere and through this experience worked with a number of departmental officers

who were designing the new model for community based support provision of mental health services and developed an appreciation of the historical development of the thinking behind this model.

6 My experience in aged care further developed when I took on the role of inaugural Executive Director of the Alzheimer Society of Victoria. I worked extensively with carers and learnt much about the mental health challenges faced by carers of people with dementia across Victoria. I was responsible for the planning and development of the first counselling service and training services of the Society and the establishment of the first dementia information line in Victoria

7 From 1992 – 1996, I was a Director and senior consultant in MGM Consultants, which specialised in disability services. I was a senior consultant on a range of projects, including a performance improvement strategy for members of the then Victorian Guardianship Board, Organisational Review of the Victorian Council on the Ageing, Consumer participation in the quality assurance of services for the Disability Advisory Council of Australia, development of an education package on safety and security for older people for the Victorian Ministry of Police and Emergency Services. This work formed the basis of the establishment of the Confident Living for Older People Program and the development of an evaluation framework for disability advocacy services for the Commonwealth Department of Human Services and Health (1995).

8 From 1994 – 2004, I was Chief Executive of Silver Circle Home Support Services, a business delivering home and community based services to people with a disability, older people and carers. I was founding CEO and Director, and built the business to become one of the largest community care providers in Australia at that time, supporting over 8,000 clients per year by 2004, at which time Silver Circle was purchased by Ramsay Health Care. I managed the community care division for a while, and integration of this business into a large public health care company.

9 From 2005 – 2007 I held the position as senior policy Officer with the Victorian Council on Ageing. I gave policy advice on a range of policy matters and was a member of on the working party, chaired by the Honourable Barney Cooney, that made recommendations to the Victorian Government on how to respond to elder abuse in Victoria.

10 In 2007, I was appointed by LaTrobe University as Associate Professor in the School of Social Work and Social. This was a joint academic\industry appointment with the Brotherhood of St Laurence. I had teaching and research responsibilities and managed the social disadvantage and ageing unit in the Brotherhood's Policy Centre. During this time, I researched and developed position papers on consumer directed care, housing affordability and social isolation. I was the Industry representative for the Aged and

Community Services Association on the management committee of the Australasian Journal on Ageing.

11 For the decade from 2009 to 2018, I was Chief Executive, Mind Australia, Specialist Community Mental Health non-government organisation. During this time I built an extensive understanding of the workings of Victorian operations in what was historically called psychiatric rehabilitation services and more recently been re-badged as Mental Health Community support services. I had strategic and management responsibility for the delivery of a range of community, residential, specialist and innovative services which grew to assist over 10,000 clients and 20,000 carers and family members across four states in Australia, with a significant proportion of the organisation operating in Victoria. Mind is a major provider of adult and youth PARC services in Victoria and I was deeply involved in Mind's growth as the major provider of PARC and sub-acute residential services in Australia. In this role I had the opportunity to work closely with staff from the Mental Health Branch in Department of Social Services (**DSS**), a number of Victorian mental health ministers, most of the public hospital networks senior mental health staff and was a an executive member of VICSERV, the then name for Mental Health Victoria from 2009 – 2014, a member of several formal mechanism by the Department considering Reforms to community mental health services. I was also a member of the Victorian Police Mental Health Liaison Group for several years. Through this experience, I built a detailed knowledge of the strengths and weakness of the structure and provision of community mental health services in Victoria and other States and Territories in Australia. Mind offered me the opportunity to work with and learn from many people with lived experience of severe mental illness and to contribute to Mind's and the state community mental health sector's maturing in our understanding of recovery based practice and supporting people with mental health to take greater control of their lives and the management of their lives, their illness and the many social and economic disadvantages that they generally have to negotiate. While I have learnt much from my work experience and academic qualifications, I have learnt as much from listening to and understanding how people with mental illness manage to use and negotiate the services and resources provided to them.

12 My experience and technical knowledge was further enhanced by my appointed as the Victorian Government nominee to the Independent Advisory Council to the National Disability Insurance Agency in 2013 and re-appointed in 2017. On this Council I worked closely with Rhonda Galbally, Council Principal Member and Janet Meagher who was a fellow Council member. Janet and I had portfolio responsibility for participants with severe and persistent mental health issues for the Council and worked with Council members to provide a number of pieces of formal advice to the National Disability Insurance Agency Board on relevant issues. This included the drafting of a paper, "Mental Health in the NDIA" that was adopted by the Council in December 2014 and

contributed to the NDIA Board's strategies for improving the responsiveness of the Scheme to the specific needs of people with severe and persistent mental illness.

13 I was one of three community mental health experts on the Expert Advisory Panel for the development of the National Mental Health Service Planning Framework. The Commonwealth State Government initiative developed this framework, which has subsequently been taken up by the Commonwealth Department of Health and state and territory governments. This planning document is a key national and state resource with regard to the projection of resource requirements for clinical and psychiatric rehabilitation services.