Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF PROFESSOR IAN HICKIE AM

I, Professor Ian Hickie AM, Co-Director, Health and Policy at the Brain and Mind Centre, University of Sydney, say as follows:

1 I make this statement on the basis of my own knowledge, except where otherwise stated. Where I make statements based on information provided by others, I believe that information to be true.

2 I am giving evidence to the Royal Commission in my personal capacity and not on behalf of any organisations of which I am a member.

Background

Qualifications and experience

3 I am a medical practitioner (MB BS, UNSW, 1982) and clinical psychiatrist (MD UNSW, 1990, FRANZCP 1989), specializing in the clinical management of common mood disorders.

4 From 2000 to 2003, I served as Chief Executive Officer of Beyond Blue, and from 2003 to 2006, I served as its Clinical Advisor.

5 In 2003, I was appointed as Executive Director of the Brain and Mind Research Institute and then, in 2015, as the Co-Director for Health and Policy of the enhanced Brain and Mind Centre of the University of Sydney.

6 In 2008, I was appointed to the Federal Health Minister's National Advisory Council on Mental Health. In 2010, I was appointed to the Mental Health Expert Advisory Group.

7 From 2012 to 2018, I served as an inaugural Commissioner of Australia's National Mental Health Commission, overseeing enhanced accountability for mental health reform and suicide prevention.

8 From 2014 to 2017, I was a member of the Medical Advisory Panel for Medibank Private.

9 In 2015, I became a fellow of the Australian Academy of Health and Medical Sciences.

10 I am a National Health and Medical Research Council (**NHMRC**) Senior Principal Research Fellow (from 2013 to 2017 and currently from 2018 to 2022), having previously been one of the inaugural NHMRC Australian Fellows (from 2008 to 2012).

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

Research interests and achievements

11 I have had an extensive research practice in clinical psychiatry, with a particular focus on common mood disorders, depression and bipolar disorder in young people, early intervention, the use of new and emerging technologies and suicide prevention.

12 I have published a range of materials on these topics, including academic papers, books, media articles and research reports.[1]

13 In partnership with Professor Patrick McGorry AO, I developed a clinical staging framework for emerging and severe mental disorders in young people.

14 I lead an NHMRC Centres of Research Excellence (**CRE**) team in optimising treatments for young people with emerging mood disorders. I was a chief investigator in the NHMRC CRE for improving suicide prevention in Australia, led by Professor Helen Christensen. I now lead a new CRE on youth suicide prevention in health services, in partnership with Orygen Youth Health (2019-23).

15 I am a member of a number of international studies which have examined the onset of emerging mood disorders in the wider population.

16 I am currently leading a long-term prospective study of adolescent twins, which involves tracking real-time developmental trajectories of the onset of anxiety and mood, psychotic or substance misuse disorders through adolescence and young adulthood. This unique study, now at the 20-year reassessment mark, will determine the extent to which neurobiological and genetic markers can predict outcomes, to help inform the development of novel prevention or early intervention strategies.

17 I am the Chief Scientific Advisor to Innowell, the organisation formed by the University of Sydney and PwC to deliver the Commonwealth government-funded "Project Synergy", a three year program for the transformation of mental health services through the use of innovative technologies.

18 Attached to this statement and marked 'Attachment IH-1' is a copy of my CV.

My current role and responsibilities as Co-Director, Health and Policy at the Brain and Mind Centre

19 I was appointed as Co-Director, Health and Policy of the Brain and Mind Centre in 2015.

[1] A comp ete st of my pub cat ons s ava ab e on the Un vers ty of Sydney webs te <https://www.sydney.edu.au/med c ne-hea th/about/our-peop e/academ c-staff/ an-h ck e.htm #co apseReStudents> [accessed 1 Ju y 2020].

20 In my role as Co-Director, Health and Policy at the Brain and Mind Centre, I lead a variety of co-ordinated research programs with other academic disciplines (notably in education, health systems development, economics and IT technologies) within the University of Sydney as well as representing the University in external partnerships with health system partners, industry, and governments.

COVID 19

The impact of COVID-19 and the need for a regional approach to mental health services

The social context of mental health

21 One aspect of mental illness that makes it considerably more complex than other health conditions is the way in which it is informed by social context. Economic, social and political factors can strongly influence and shape the nature of the mental health issues that arise in society.

22 We are fortunate that Australia is currently one of the most mentally aware countries in the world. However, this also means that community expectations about mental health, and particularly the standard of mental health care, are increasing. This has been reflected in the National Cabinet's positive response to the COVID-19 pandemic, which has seen Australia prioritise mental health more highly than in many other countries.

23 A person's mental health is founded upon two pillars. The first is personal autonomy, which includes having control over your own life through maintaining good health, accessing the appropriate welfare and supports, and obtaining the education and skills required to thrive in modern society. The second is social connection, which requires that people be able to live and work in a socially cohesive and inclusive society that provides adequate support to those who are marginalised (whether by illness, socio-economic factors, geographical factors or cultural factors).

Mental health during global crises

24 The impact of a global crisis on society depends on the nature of the crisis. For example, during times of war, the presence of an external threat often unites society and unemployment and suicide rates usually fall. In contrast, economic recessions will generally cause the reverse to occur: unemployment and social dislocation increase, and so do suicide rates, psychiatric hospitalisations and presentations to emergency departments (**EDs**). The net result is typically an increase in the demand for mental health services.

25 More significantly, a recession does not impact all parts of society equally; the impact on the vulnerable and the marginalised, such as those with housing issues, less secure employment, family issues or mental health issues, is disproportionately high.

26 In addition, the impact of a recession will vary from region to region. How a given region responds to such a crisis will depend on a range of socio-economic and demographic factors particular to the population in that region. As noted above, it is these factors which colour the social context in which mental health issues manifest.

Defining the scope of a regional approach to mental health

27 In my view, understanding the impact of the COVID-19 pandemic on a regional level is critical to both navigating the immediate challenges posed by the pandemic and prioritising the appropriate long term reforms of Victoria's mental health system.

28 When one considers how to analyse the relevant factors that inform the social context at a regional level, the first task is to define the relevant regions. The existing health system comprises a patchwork of intersecting regions and networks, such as those covered by the Primary Health Networks (**PHNs**) and Local Health Networks (**LHNs**). However, the problem with these regions and networks is that they are not aligned and do not form a cohesive whole. In my view, a more useful approach would be to divide Victoria into a number of "functional regions", being areas defined in terms of demographic, socio-economic and geographical factors. As noted above, it is these same factors that inform the social context in which mental health issues arise.

29 It is important that the scale of these functional regions be appropriate. When Simon Crean was the Minister for Regional Development, a set of regional maps were created in which Australia was divided into about 55 regions, about six to eight of which comprised Victoria. In my view, the scale of these regions is comparable to what I consider would be appropriately sized functional regions.

Limitations of the current mental health system in light of COVID-19

30 Health systems are, by their very nature, risk averse and slow to evolve. In my view, we have been stuck in the same mode of thinking in relation to the mental health system since the 1980s, when the transition was made from the asylum system to more community-based forms of care. We have struggled to come to terms with what a modern mental health system, situated within a federal political structure, should look like.

31 The clearest manifestation of this problem is the continued preoccupation with increasing hospital bed numbers as the primary means of growing system capacity. Hospital beds represent one of the most expensive resources in the current system. The real challenge in Australia lies not in sourcing additional funding for more beds, but rather in achieving

the right balance of traditional forms of hospital-based care and an appropriate range of specialised and community-based services, many of which are provided in ambulatory care settings, required to meet the ever-growing demand for mental health services.

The impact of COVID-19 on demand for mental health services

32 There has always been a tremendous amount of unmet demand in the mental health system. Even before the COVID-19 pandemic, unemployment and suicide rates were already rising in many regional areas. With the onset of the COVID-19 pandemic, a lot of that demand is going to be introduced into the system in various ways.

33 The Royal Commission provides an excellent opportunity to reflect on how to deal with this. While there is an urgent need to take action in the short term, the danger of swiftly responding to the current crisis is that this will come at the expense of addressing what I consider to be the more difficult and fundamental questions concerning the future of Victoria's mental health system.

Limitations of the existing epidemiological framework for mental health care

34 There must be a clear plan for meeting this surge in demand. In my view, many of the traditional diagnostically driven ideas and concepts developed in the 1980s post-asylum era do not map well onto the actual health care needs of patients. For example, the epidemiological pyramid developed during this period is based on rigid categories of "mild", "moderate" and "severe" mental health disorders (schizophrenia being an example of a "severe" disorder and anxiety being an example of a "mild" disorder). Based on these categories, the population comprises approximately 2-3% of people who suffer from severe disorders, 5-6% who suffer from moderate disorders and the remaining 20% who suffer from mild disorders.

35 Not only do these categories fail to reflect the complexity of mental health disorders (for example, they do not capture the various degrees to which people experience different forms of psychological distress or the reality that the severity of mental disorders can change over time), they have led to a system that has, due to its limited capacity, consistently prioritised the 2-3% of the population that is categorised as having a "severe" mental disorder, often to the neglect of many of the people who fall within the "moderate" and "mild" categories.

36 With the onset of the COVID-19 pandemic, many people who may have previously been categorised as having "moderate" or "mild" mental health disorders have presented to the system seeking help. In a system with limited capacity, continued growth in demand will (without a corresponding increase in capacity) result in the same services being stretched across a larger population base, with the result that consumers will each have access to a smaller share of that limited capacity.

37 The problem with the current system is that, not only is there insufficient capacity to meet this growing demand, there is no clear allocation of responsibility for service provision at a regional level. This is discussed in greater detail below.

Long term opportunities for new approaches to service delivery that could benefit consumers and carers

A regional approach to managing demand for mental health services

38 In order to manage the growing demand for mental health services in Victoria, there must be structures and systems in place at a regional level to effectively assess, monitor and manage the particular needs of the population within each functional region.

39 In designing such structures and systems, consideration should be given to:

(a) The number of functional regions within Victoria that each need to be adequately serviced;

(b) The particular demographic, socio-economic and geographical factors at play in each functional region. This may include education opportunities, unemployment (and youth unemployment) rates, housing availability and the availability of other social welfare supports;

(c) The pre-existing challenges and issues present in each functional region prior to the COVID-19 pandemic (such as increasing suicide rates in some regional areas); and

(d) The existing service networks, infrastructure and key actors in each functional region.

Identifying the key actors in each functional region

40 In order to ascertain the particular needs of a given functional region, one must first identify the key actors (such as service providers) operating in the region, as well as the infrastructure, workforces and other resources available to those actors. These may include traditional state networks and services (such as LHNs), networks and services funded by the Commonwealth government (such as PHNs and entities subsidised through the Medicare Benefits Schedule, or **MBS**), privately owned services and infrastructure and non-government service providers. Services and programs supported under the National Disability Insurance Scheme (**NDIS**) will also be relevant; there is often a strong overlap between state-run services and those that are supported and funded under the NDIS.

41 Once the relevant actors, infrastructure and other system resources have been identified, one can then consider how the particular needs of each functional region can be met most efficiently.

Meeting demand: the allocation and sharing of responsibility between different levels of government

42 Historically, the states have been responsible for service delivery. This is despite the fact that it is the Commonwealth government that provides funding for many of these services. This disconnect between the source of funding and the ultimate responsibility for service delivery has been a longstanding point of tension in Commonwealth-state government relations. The COVID-19 pandemic has demonstrated that there must be a fundamental re-evaluation of the established allocation of roles and responsibilities across the federal and state levels of government.

43 When the demand for mental health services exceeds system capacity (which was already the case before the COVID-19 pandemic), the burden of that excess demand will fall on the states. This explains why the capacity of mental health services has always been considered through the lens of state-run services.

44 This needs to change. The Victorian government has a responsibility to govern for the entire population of Victoria. That fact does not change the reality that the State government cannot be the sole provider of services in a properly functioning system that is capable of meeting the particular needs of the population within each functional region.

45 Any proposed system reforms must be underpinned by a recognition that, unlike the health systems in the United Kingdom and the United States, the Australian health system is a hybrid system. The problem of managing constantly growing demand for mental health services cannot be solved by the Commonwealth government simply providing states more funding; as noted above, the states cannot be the sole provider of services in a properly functioning mental health system.

46 In my view, a key opportunity for securing greater Commonwealth engagement and accountability will be forging partnerships between PHNs and other kinds of service providers (whether they be state-based, private or non-government providers). This is because it is the PHNs that have become the vehicle for Commonwealth funding in the sector. Promoting the creation of partnerships involving the PHNs can both leverage Commonwealth funding and also increase Commonwealth engagement with and responsibility for service delivery within the regions covered by PHNs.

47 Ultimately, the Commonwealth government must be committed to any proposed long term system reform in Victoria. The Royal Commission's deliberations on the future of

Victoria's mental health system cannot be conducted without regard to the federal context in which the system operates.

Confining the role of the State as a service provider

48 The logical corollary of the acknowledgement that Commonwealth and state governments should be jointly responsible for meeting system needs at a regional level is that the states need to focus more on the quality of the services they *can* provide (based on existing system capacity), rather than trying to provide the full spectrum of services for the entire population.

49 The traditional domain of state-based services is forensic and acute care; for example, states are responsible for the maintenance and operation of hospitals and EDs. However, states are not as well-equipped to provide other forms of specialist care. For example, states have traditionally struggled to recruit and retain experienced specialist medical practitioners (such as psychiatrists and psychologists), who typically prefer to work in the private sector.

50 Rather than trying to expand capacity in other areas of mental health care, states should be aiming to improve the quality of their existing forensic and acute care services. However, as noted above, this approach necessarily involves actively engaging with the Commonwealth government (and Commonwealth funded networks such as PHNs) to better leverage and coordinate Commonwealth funded services and resources, and existing private infrastructure and workforce capability.

Public purchasing of private infrastructure

51 The public purchasing of private infrastructure is a key means for growing system capacity and for relieving the pressure on state facilities (such as hospitals and EDs) that has not been properly exploited to date in Australia.

52 One common effect of recessions is that many people choose to remove their private health insurance. This means that large private health providers, which may have a lot of existing infrastructure, now have a shrinking population base that is using that infrastructure. Some private health providers also offer what are known as day programs, which are large and complex care programs designed as an alternative to hospitalisation or to assist patients in making the transition from hospital admission back to their home. However, in their current state, these represent a poor value to consumers.

53 The public purchasing of private infrastructure has been used to great effect by the Commonwealth government in response to the COVID-19 pandemic. The Minister for Health, Hon Greg Hunt, took decisive action under government regulations to make

existing capacity (in the form of intensive care beds and ventilators) in the private sector available to all.

54 I am firmly of the view that state governments can and should take similar measures to build capacity without having to provide additional services or build additional infrastructure themselves.

Using private infrastructure and services to effect divergence from emergency departments

55 One application of the public purchasing of private infrastructure that is of particular interest to me is utilising private infrastructure to effect a divergence of demand from EDs.

56 As noted above, when the demand for mental health services exceeds system capacity, the burden of the excess demand typically falls on the State, and particularly in the form of an increase in presentations to EDs. The problems caused by this excess in demand can be self-perpetuating. Many people who present to EDs are poorly dealt with, often because they simply cannot obtain the care and treatment they need, or because the EDs are at full capacity and are forced to turn people away.

57 I encountered a stark example of patients not receiving the care they need while I was residing in Victoria in the 2000s. In 2006, I worked with the Human Rights Commission in producing a report titled the "Not for Service Report",[2] the name for which was derived from a service in East Gippsland which had stamped the words "not for service" on the file of one of its patients. When asked why this had been done, the service responded that there was nothing further that could be done for that patient.

58 One way in which the system could better cope with the increased pressure on EDs would be to secure short term crisis admission infrastructure. This could be in the form of private hospital facilities that are purchased by the State to provide short term crisis admission services to the "missing middle" (discussed further below) and those who would otherwise present to EDs and not receive the care and treatment they need. Once patients admitted to such facilities complete their short term crisis admission, they could then be linked into appropriate forms of ongoing care provided by Commonwealth (MBS) subsidised services. Leveraging private infrastructure and services in this way would not only ensure that people are more likely to receive ongoing and appropriate care that meets their individual needs, it would relieve some of the pressure on EDs, which could then provide more care to those who need it most.

[2] The report s ava ab e at <https://humanr ghts.gov.au/s tes/defau t/f es/content/d sab ty_r ghts/notforserv ce/documents/NFS_F na doc.pdf> [accessed 1 Ju y 2020].

59 A critical ingredient for this kind of linking and coordination of private infrastructure and services is having robust information technology and data collection systems. The existing health information systems are not equipped to allow people to easily control and transfer their personal health information to and between different service providers. This is discussed further below.

Research on prolonged quarantine or social distancing measures and their impact on wellbeing and mental illness

60 Prolonged social isolation, along with less severe forms of social distancing and dislocation of normally supportive social structures, can have adverse effects on mental health. The extent of the impacts depends on both the degree of isolation (i.e. quarantining one's self either alone or as part of a small family or other group), as well as the duration of the event requiring isolation.

The Missing middle

Allocating responsibility for the missing middle

61 The group often referred to as the "missing middle" comprises people who have moderate to severe and complex mental health disorders. The term was adopted because this group does not currently receive the more specialised, intensive and extended care in ambulatory settings which it needs.

62 In my view, there should be joint Commonwealth and state responsibility for the missing middle. This could be driven, for example, through organised collaboration between PHNs and LHNs, which are funded by the Commonwealth and state governments respectively. As noted above in relation to the wider mental health system, the states cannot solve this problem on their own.

High priority reforms that should be considered by the Royal Commission to address the issue of the missing middle

63 There are a number of key reforms that should be considered by the Royal Commission, several of which have already been discussed above in this statement.

64 The first is creating a regulatory environment that facilitates the efficient public purchasing and utilisation of private infrastructure. Scale will be very important in this pursuit; governments and commissioning bodies should focus on purchasing from large providers to achieve economies of scale. Until recently, this had not been the approach taken by the North Coast Collective, a regional partnership based in the Northern Rivers region of NSW (see [150] below), which had entered into around 160 separate service contracts with small businesses. It would be more efficient for governments, PHNs, local networks

or any other regional body formed to oversee the commissioning of services to contract with service providers who are operating at a sufficient scale and capacity to be able to meet the needs of the particular population base in that functional region.

65 The second is providing a framework for the efficient co-commissioning of mental health services among different service providers and networks within each functional region. Indeed, this is already being done by some of the more forward-thinking PHNs and LHNs; they are examining the particular needs of their population base and are then contracting with service providers for the provision of the services required to meet those needs.

66 Steven Duckett, the Chair of the East Melbourne PHN (which covers a population base of around 1.5 million people), has shown an interest in exploring how the Commonwealth and state governments could leverage private infrastructure and services to meet the needs of their population. I understand that preliminary discussions have been held at the Victorian Department of Health and Human Services regarding the form of organisational structures that would be required to facilitate this.

Infant, children and youth mental health

Ways in which developmentally appropriate care differs across different age cohorts

67 One of the issues with the current health system is that it was not designed to account for the complexity of development that differentiates various age cohorts.

68 In my view, we need to adopt a more segmented and tailored approach to infant and youth mental health care that specifically addresses the complexities and different needs of the following age cohorts:

(a) Minus nine months to twelve months: this includes pregnancy, perinatal, early post-natal and infancy. The needs of the mother (and the whole family) are important in this period.

(b) One to five years: this is a critical period in which various mental issues may arise, including autism and attention deficit disorder, as well as other neuro-developmental difficulties and early forms of anxiety.

(c) Five to twelve years: this includes the primary school period, during which learning difficulties and other developmental difficulties may arise.

(d) Twelve to sixteen years: this period sees the emergence of mood disorders and other mental health issues.

(e) Sixteen to twenty-five years: this period sees the transition from adolescence to early adulthood with a corresponding change in how mental health problems

present (reflecting later phases or brain development, particularly related to frontal lobe structures and their more complex cognitive functions) and their implications for longer-term adult social and economic participation.

69 There have been some important developments in federal policy, instigated by the Turnbull government, in relation to early childhood care and education. The clear emphasis here was the shift in focus from early childhood care ('childcare for working parents') to early childhood education (the opportunity to benefit from earlier education-based social and cognitive experiences, as well as earlier active interventions for identified cognitive and emotional difficulties). These policy reforms acknowledged the need to more effectively address early developmental difficulties and neuro-developmental issues, which are particularly prevalent in more vulnerable parts of the population, such as indigenous people.

70 In my view, to better address the particular challenges associated with each of the above age cohorts, it is critical to develop partnerships between the mental health sector and the right institutions and care providers. For example, in the minus nine months to twelve months cohort, this would involve partnerships with perinatal services, obstetrics, paediatrics and other family support services. In the one to five years cohort, this would involve partnerships with early childhood education institutions, which might entail making available to families consultations and assessments for autism and other early neuro-developmental disorders. In the five to twelve and twelve to sixteen year cohorts, this would involve partnerships with pre-school institutions and schools. In the 16-25 cohort, partnerships with universities, TAFE institutions and other post-school education and training would be critical.

71 In the early childhood development space, the earlier identification of autism spectrum disorders, and the linking with more effective early interventions offers particular hope – at least for less severe forms of these disorders.

72 Although mental health services have not traditionally had a prominent role in any of these industries, mental health expertise, whether in the form of consultation or assessment services, is really critical.

My research on the development of the brain and the age at which it is understood to reach maturity

73 The research I have conducted in this area has demonstrated the complex and multi-faceted nature of the developmental trajectories that span each of the age cohorts discussed above.

74 In addition to brain developmental changes continuing throughout adolescence and early adulthood, there is also increasing recognition of the degree of variation between individuals at the same chronological age. Consequently, much more personalization of assessment and intervention is required.

75 In my view, the current health system does not adequately account for these developmental complexities or heterogeneity of presentations. It is a system based on an outdated hospital-based model of care that is premised on an overly simplistic understanding of age and brain development. This model comprises three basic stages of life: childhood (to which paediatric services are directed), middle aged adult life (to which specialist treatments for diseases such as cancer and heart disease are directed) and the geriatric phase. Our specialist hospital services have traditionally been heavily focussed on the common health issues associated with middle aged adults, such as cancer and heart disease.

The importance of early intervention

76 Early intervention serves to address different problems that commonly arise in different age cohorts. It therefore needs to be understood in terms of the age of onset of each of the corresponding developmental issues that may arise at that stage of development.

77 For the pre-natal and post-natal periods, early intervention is critical to pre-empting the onset of post-natal depression in mothers. The task here is to diagnose anxious mothers during the pre-natal phase (that is, before the onset of post-natal depression). Back in 2000, I was involved in this kind of early intervention work with Beyond Blue. We discovered that it was possible to detect approximately two-thirds of post-natal depression cases in the pre-natal phase (before the baby is born).

78 For the one to five year cohort, early intervention is critical to addressing autism, attention deficit disorder and other neuro-developmental issues.

79 For the five to twelve year cohort, early intervention serves to address anxiety, which is common among primary school children.

80 Early intervention becomes increasingly important from the age of about twelve years, when mood disorders can begin to emerge. This is particularly important for girls, when self-harm and other forms of psychological distress begin to manifest, with the more severe psychotic illnesses becoming more prevalent around the ages of fourteen to sixteen. Early intervention for the twelve to sixteen year cohort is also important in preventing or addressing drug and alcohol problems that may worsen over time if not dealt with early on.

81 Secondary prevention and impairment mitigation are also important aspects of early intervention measures. For example, managing impairments that manifest in adolescents might involve by working with schools and employers to keep adolescents in school or in employment.

Design considerations that differentiate the infant, children and youth system from the adult system

82 A key criticism of the current system is that it is fundamentally reactive in nature. It was designed to intervene only once illnesses reach a certain (high) threshold of severity. This is a short-sighted approach to health care; we need a system that accounts for what is now the common understanding that many chronic mental health issues that manifest in middle aged people can be prevented or at least mitigated if appropriate forms of intervention are deployed at earlier stages in life.

83 We need to understand the mental health needs of infants, children and adolescents as episodes of care that must largely be dealt with in the community; the hospital system should only be an option of last resort. The existing specialist hospital-based model was primarily designed to provide paediatric services for rare childhood disorders (not including adolescent disorders), specialised treatments for common conditions prevalent in middle aged adults (such as cancer and heart disease), and limited forms of geriatric care. This system does not cater for the complex developmental transitions that feature in early stages of life, most of which are not suited to traditional forms of hospital-based treatment.

84 One common issue I have encountered in my recent discussions with various state leaders is the tendency to broach the topic of reform in this area in terms of the existing system. That system is not fit for purpose; the complexities raised by mental health issues demand more specialised consultation and assessment services and complex, multi-disciplinary intervention in ambulatory care settings. We also need more sophisticated data tracking to monitor the effectiveness of such forms of care and intervention.

Implications for workforce capability

85 To design a system capable of providing the specialised and multi-disciplinary services mentioned above, the mental health workforce must be recruited and trained accordingly. Historically, the opposite approach has been taken: we have recruited a workforce with a more generic skill base because they are easier to employ.

Limitations of "stepped" models of care

86 I am a critic of what is often referred to as "stepped care" models. Under these models, all patients receive the same form of generic initial care. If that initial form of care is not successful, patients are progressed to the next level of care; the process then continues throughout multiple levels. The result of this approach is that people with the most severe mental health problems tend to wait the longest amount of time to receive the appropriate care. In my view, this "top down" planning approach to public health care is inefficient because it fails to cater to the individual care needs of patients.

87 On the other hand, as discussed below, I am a strong advocate of staged care models that prioritise providing the right care to patients the first time. This can be achieved through proper assessment of the patient's needs so that the appropriate treatment or intervention can be identified, interventions in other relevant risk factors (such as unemployment and alcohol and other drug use) and the systematic monitoring of outcomes to ensure that treatments or interventions can be adjusted as required.

88 In the context of infant, children and youth care, the system should be capable of targeting and addressing the most prevalent mental health issues that tend to arise within a given age cohort (identified above). This is far more effective and efficient than delivering bulk forms of unspecialised care that are not appropriate for many individuals with more severe illnesses. Adoption of this staged care model would involve tailoring the system so that it more directly addresses the more prevalent issues that tend to arise at each of the developmental phases set out above (at [68]).

Intake and assessment

Opportunities to use online assessment tools to overcome the limitations of traditional service intake and delivery methods

89 In 2020, people expect to have ready access to online tools that provide greater choice, convenience, lower cost and higher quality care. In my view, the current system has done a poor job of understanding and accounting for the complexity and multi-faceted nature of people's mental health needs, which often require access to a range of services in an appropriate sequence. In reality, when people present at a service that only has one specific function, the service will often try to make the consumer's needs fit its service offering, rather than consider their needs on a more holistic level.

90 In my view, it is entirely possible to better utilise online assessment tools and processes. In the past, much of the workforce was dedicated to manual tasks such as asking people questions that may be self-evident, interpreting the answers to those questions and writing down their interpretation. Instead, people should be able to directly input that data into online systems, which can then enable services to determine the precise nature of

the services required. In my view, this should be possible for the majority of ambulatory care presentations, with the exception of the more serious or acute presentations.

91 In terms of the implications for the mental health workforce, the proper implementation of these online assessment and intake tools would greatly reduce the need for low-skilled workers who perform basic assessment and intake tasks. Instead, more specialist practitioners would be needed in order to be able to meet the complex and multi-faceted needs of consumers.

92 These online assessment tools can also facilitate the tracking and monitoring of individual consumer needs over time. They can encourage a more collaborative and inclusive approach to ongoing care; consumers, their families and carers can be more directly involved in identifying and managing the consumer's needs.

Examples of online assessment tools or processes and their implementation

93 One example of the application of these online assessment tools is a Commonwealth-funded project I led known as Project Synergy. As part of an international team, we developed an online platform to assist in the assessment, feedback, management and monitoring of people with mental disorders with the aim of improving the quality of mental health care provided by traditional face-to-face services.

94 Project Synergy has been tested in several population bases, including university students, disadvantaged communities in NSW, people at risk of suicide and attendees of headspace centres.

95 The studies undertaken as part of Project Synergy also raise a number of socio-political concerns about the potential impacts of health information technologies. Those responsible for the future implementation of online and digital tools and services will need to adequately address these concerns.

The role of telephone helplines in the digital era

96 The role of telephone helplines and digital services raise two interesting and interconnected issues: one being how people access health care, the other being how the system can meet the consumer desire for human connection.

97 Telephone helplines have become popular because they cater to the desire for human connection. Many people like speaking to caring and decent people about their problems, and some people would prefer to be speaking to a lay person rather than a health professional.

98 In my view, telephone helplines create another source of demand. The more helplines there are, the more demand there will be for mental health services. These helplines are only effective to the extent they can connect callers to the right services and care; this does not happen if the system is congested by chronic users who continue to call helplines even after accessing (or being referred to) other health services.

99 Instead, we should be prioritising the development of other forms of peer support and human connection that can be facilitated by digital technologies. These technologies are a great way of mobilising peer support, and can still provide (at least to some limited extent) the human connection consumers seek. In addition, they can be very effective as a platform for providing more targeted non-professional social support.

Core components of care

Limitations of the core components of care as a conceptual framework for mental health planning

100 In my view, the core components of care is a problematic conceptual framework for mental health planning. As soon as one attempts to define each of the four components of care for different age groups, the imperative to ensure fidelity to those core components limits the scope for care to meet the particular needs of individuals.

101 This framework reflects the "top down" planning approach that underpins each of the national service improvement frameworks, to which most states still subscribe. As noted above, I consider that this rigid planning approach is not suited to meeting the specific needs of population bases within each functional region. It does not account for the infinite scope for variation in need among regions, families and individuals. It also reflects how individuals' mental health needs have been poorly defined (for example by age or by diagnosis) in the existing system.

102 Despite its origin as a national scheme, I consider that the design philosophy underpinning the NDIS, that every case has its own set of particular requirements, is correct. The NDIS approach also recognizes that every family, including its resources and circumstances, is different. This 'home-based' and 'additional strengths' approach is also well suited to the mental health sector.

Care pathways

The transdiagnostic 'stage-based' stepped model of care

103 This model of care is designed to identify the right kind of care at first instance and then recalibrate the intensity of care[3] (as necessary) based on the use of ongoing tracking and monitoring technologies.

104 The key features of this model are:[4]

(a) Assessment and staging: the primary purpose of this stage is to match the patient's level of need with the appropriate form of care (or treatment intensity).

(b) Treatment intensity: the treatment or intervention should correspond to the patient's level of need. Early-stage interventions generally carry less risk and are less time intensive than later-stage treatments.

(c) Intervening in other risk factors: supplementary intervention should be provided to address coexisting risk factors linked to poor outcomes and deteriorating mental health, such as unemployment, alcohol and other drug use, poor physical health and social disconnection.

(d) Assertive monitoring of outcomes: treatment progress and outcomes should be monitored routinely and systematically. Ideally, consumers would have direct and transparent access to their own data to facilitate shared treatment planning with clinicians.

Care pathways: the need for flexibility

105 Care pathways are based on commonalities that typically appear in certain groups. For example, if one considers people who present to services such as headspace, about half of that population could be allocated to a care pathway that could be effectively managed through a combination of digital assessment and monitoring tools and supervision by relatively low-skilled workers. Another third of that population might be identified as being in an "at risk" state, which means it may be unclear how their condition will change or develop and they may require close and regular monitoring.

106 This is why care pathways should not be overly rigid or deterministic. If a person is allocated to a particular care pathway, but it subsequently becomes apparent that that

[3] The ntens ty of care may be def ned n terms of f nanc a cost (both serv ce eve and consumer), consumer requ rements to phys ca y attend, the requ red frequency of attendance, the number of profess ona s nvo ved, the engh of the ep sode of care and the prescr pt on of psychotrop c med cat on.
[4] These key features are set out n more deta n Shane PM Cross and Ian H ck e, Transd agnost c stepped care n menta hea th . Pub c Hea th Res Pract. 2017;27(2):e2721712. <https://www.phrp.com.au/ ssues/apr -2017-vo ume-27- ssue-2/transd agnost c-stepped-care- n-menta - hea th/> [accessed 30 June 2020].

care pathway is not appropriate for that individual, they should be progressed to an alternative care pathway.

Managing demand and workforce capability

107 Properly staging care can also be an effective way of managing demand; rather than directing people to generic forms of care that do not meet their individual needs (and places further pressure on a system that is already operating at capacity), we should be developing ways to more accurately assess and monitor those needs to ensure they receive the right care at first instance.

108 In addition to the digital technologies that can assist in managing demand in this way, we also need to consider how the different elements of the mental health workforce are deployed. The less skilled and peer elements of the workforce should be allocated to the intake, assessment and monitoring work (described above) to ensure that the highly skilled professionals are free to focus on providing the more complex and specialised forms of care.

Suicide prevention

Key priorities the Royal Commission should consider in strengthening Victoria's future approach to suicide prevention

State education, employment and economic policies

109 State policies in key areas including education, employment and economics play a critical role in ensuring young people remain connected with various forms of education and employment opportunities.

110 Adolescents aged around seventeen to eighteen who drop out of school face an increased risk of mental health issues and are strongly associated with social isolation and suicide. It is therefore essential to provide adequate psychosocial supports to this demographic. Education is a lifetime investment and disruption at this key stage of life can have major long term ramifications for an individual's mental health.

111 These psychosocial supports should also be extended to the university and vocational education training (**VET**) sectors. While active mental health support has attracted a lot more attention in the university sector, the outsourcing to many private providers in the VET sector has been associated with less development of relevant services for this group.

The public purchasing of private infrastructure

112 This has already been discussed at length in this statement above.[5] Leveraging private infrastructure will be critical to ensuring that people at risk of suicide who present to EDs are not simply turned away because they do not meet the particular threshold requirements for receiving traditional forms of hospital-based care. As explained above, these people could instead be admitted to short term crisis facilities (private infrastructure) and then be linked into appropriate forms of ongoing care provided by Commonwealth (MBS) subsidised services.

Digital assessment, coordination and systems modelling tools

113 We need more sophisticated means, through the use of digital technologies, of detecting and monitoring those at risk of suicide. In addition, the factors driving suicidal behaviour need to be more effectively tracked and analysed at a regional level. Systems modelling and simulation tools offer significant potential for regional decision-makers to better understand and respond to the particular drivers of suicidal behaviour in their own regions and to more effectively allocate their limited resources.[6]

114 As noted above, the effective use of sophisticated monitoring and planning tools can also relieve some of the pressure on EDs if people at risk of suicide can receive early interventions and be directed to appropriate levels of care without having to present at a hospital or ED.

Partnerships within functional regions

115 Another way of relieving the pressure on EDs is to better utilise information technology systems to link and coordinate other services through regional partnerships (discussed above). To encourage people in distress to come forward, we need to give them confidence that they will be able to access the care they need. It is not enough to simply increase the number of telephone helplines; people must be assured that there are sufficient and appropriate services available in their local area.

[5] See paragraphs [51]-[59].

[6] Jo-An Atk nson, Adam Sk nner, Sue Hackney, L nda Mason, Mark Heffernan, D anne Curr er, Ky e K ng, Jane P rk s, Systems mode ng and s mu at on to nform strateg c dec s on mak ng for su c de prevent on n rura New South Wa es (Austra a), ANZJP June 17, 2020 <https://do .org/10.1177/0004867420932639> [accessed 1 Ju y 2020]. Systems mode ng and s mu at on too s are d scussed n further deta be ow at paragraphs [130]-[132].

Digital health services

Key opportunities and challenges for technology to enhance and transform mental health care

Opportunities

116 Technology will be the essential infrastructure of future mental health systems.

Consumer control over personal health information

117 I recall when the Rudd Government unveiled the "My Health Record" concept as part of its 2020 Vision back in 2008. My Health Record was designed to serve as a comprehensive online record of an individual's personal health information which would be managed and controlled by the Commonwealth government.

118 In 2020, such an idea now seems outdated. People expect to have ready access to and control over their personal information via smartphones and other forms of digital technology. They want to be able to choose the individuals (such as relatives) and institutions with whom they share that information. It follows that developing robust data tracking and coordination infrastructure will be essential.

119 Telehealth services already offer consumers powerful new ways of doing this by allowing them to interface with a range of digital tracking and self-management tools that enable the consumer to dictate who can access their personal health information.

Improving system efficiency and managing demand

120 Digital technologies such as telehealth can play a pivotal role in improving system efficiency and managing the growing demand for mental health services. One trend which has already emerged since the introduction of telehealth services is a reduction in the non-attendance rates at traditional GP clinics. This is because many consumers are now able to attend consultations in their own home using digital programs like Zoom and Skype.

121 The private sector could also play an increasingly significant role in meeting the steadily growing demand for mental health services. Given the limitations of the existing health system and its inability to meet this growing demand, I expect there will be an increase in the number of private service providers offering technology driven services. This would not necessarily be a positive development. Historically, growth in the private sector has been associated with inequity in distribution of services, more disconnection between care providers and increases in out-of-pocket costs to service users. A general lack of accountability, and a lack of focus on outcomes, as distinct from increased activity, has characterised private services development.

Tracking and feedback systems to improve system responsiveness

122 The role of data tracking and feedback systems in both improving service quality and system responsiveness cannot be underestimated. These tools will serve to improve understanding of the mental health system (and particularly its limitations) on both the consumer and service provider side. They can also empower consumers to be able to directly provide feedback about the system and then witness the system responding to and improving based on that feedback.

123 Digital tracking systems can also enhance system responsiveness and efficacy more generally. For example, a patient who attends a GP clinic, is prescribed certain medication and subsequently has an adverse reaction to the medication several days later may only be able to return to see their GP in six weeks' time. However, with the proper digital systems in place, the patient could simply communicate his or her adverse reaction to the GP via text message, allowing the GP to respond in a more timely manner. In this way, digital tracking and coordination systems can ameliorate some of the traditional limitations of the health care system.

Improving the experience of care, not just care outcomes

124 In my view, there are ways of improving the holistic experience of care at the system level. People can enter the system and have bad outcomes but still come away with a positive experience of care. For example, people can have a good experience of dying in palliative care.

125 Unfortunately, mental health service providers and professionals have developed a degree of cognitive hopelessness; they have become quite disillusioned about their own provision of care. This is an interesting development given that people who choose to work in mental health generally show high levels of empathy and understanding when dealing with mental health patients. There are many critical ways available to remedy this situation, but one is the wider use of digital technologies that more actively engage service users, providers and families and carers in active partnerships in care.

Challenges

126 A key challenge to the successful implementation and widespread adoption of digital technologies will be adequately dealing with the sensitivities concerning privacy and control and ownership of data. These issues are complicated by the fact that much of what we consider to be personal data is now stored in digital infrastructure owned and operated by global multi-national technology corporations. There is currently limited public understanding and transparency about what exactly happens to consumer data once it enters these digital systems.

127 This was raised as a major issue at the World Economic Forum, which published an online report on digital health care systems in 2015-16.[7]

Mechanisms and structures required to build consumer trust and confidence in technologically supported mental health care

128 As noted above, people now expect to have much greater control over their personal health information. However, the greater integration and coordination of personal health information through the implementation of appropriate digital technology platforms can only be achieved if consumers are willing to trust those systems to keep their personal information secure.

129 To build trust in these systems, consumers need to be shown the value proposition of engaging with them. They need to be able to experience for themselves how these systems can facilitate the provision of higher quality and more specialised care that is better suited to meeting their particular needs.

130 However, providing this kind of improved user experience will only be possible if the system itself (including service providers) develops sufficient capability to effectively utilise these digital tools. In the current system, the user experience in relation to the management of personal health information is very poor for both consumers and clinicians. The current iteration of medical records is inadequate and does nothing to improve the quality of care provided to consumers.

Use of data for service planning and responsiveness

The need for advanced decision-analytic infrastructure such as systems modelling and simulation

131 Systems modelling and simulation serve to facilitate the testing of various scenarios in order to inform decision-making strategy.

132 I have previously written about how public health and social policy planning in Australia has been largely devoid of engagement with sophisticated systems modelling tools.[8] In contrast, the engineering, business and finance sectors are very familiar with the value of models based on advanced computing and how to take advantage of such models to manage complexity and uncertainty and identify optimal outcomes.

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[7] The report, t t ed Hea thcare: bu d ng a d g ta hea thcare system s ava ab e at <https://reports.weforum.org/d g ta -transformat on/hea thcare-bu d ng-a-d g ta -hea thcare-system/> [accessed 30 June 2020].

[8] Jo-An Atk nson, Ian H ck e, Kenny Lawson, Systems mode ng can save us from de ayed act ons and wrong turns n po cy mak ng, The Mandar n, 4 June 2020 <https://www.themandar n.com.au/134853-op n on-systems-mode ng-can-save-us-from-de ayed-act ons-and-wrong-turns- n-po cymak ng/> [accessed 30 June 2020].

133 In my view, the absence of an appropriate predictive planning framework, based on systems modelling and simulation, is a key reason for the continued failure of Australia (and indeed other countries) to make substantial progress in improving mental health outcomes.

134 In a mental health context, systems modelling and simulation would serve as an interactive decision analytic tool to test different mental health reform and service planning scenarios before they are implemented in the real world. This would drive better decision-making and would ensure that, within each functional region, the limited available resources can be allocated as efficiently as possible.[9]

The optimal application of systems modelling tools in the mental health system

135 As noted above, in order to effectively manage the growing demand for mental health services, the mental health needs of a given population must be assessed at a regional level. In my view, the systems and modelling tools discussed above could serve as a powerful driving force to encourage the various actors in the public, private and non-government sectors within each functional region to collaborate and plan coherently at a regional level.

136 Although this has yet to be tested in Victoria, there are four regions in NSW that have begun to use systems modelling tools. Using these tools, each of these regions have been able to experiment with and predict the likely impact of increasing or decreasing the capacity of certain kinds of care on the mental health system as it functions within that region. Each of these models has been published (or submitted for academic publication).

137 The Commonwealth government is currently considering providing funding to the PHNs to develop such modelling-based regional decision-making tools.

138 Although these tools would be best applied at a regional level, there would need to be some form of state-wide oversight to ensure that the regional application of those tools complied with agreed national and state standards. The various forms such oversight might take are discussed below.

[9] Jo-An Atk nson, Adam Sk nner, Kenny Lawson, Sebast an Rosenberg, Ian B H ck e, Br ng ng new too s, a reg ona focus, resource-sens t v ty, oca engagement and necessary d sc p ne to menta hea th po cy and p ann ng, BMC Pub c Hea th 20, 814 (5th June 2020) <https://do .org/10.1186/s12889-020-08948-3> [accessed 30 June 2020].

Governance and accountability

Benefits and risks of distributing system management functions across multiple entities

139 In my view, system management functions (such as governance, oversight and commissioning) would be best performed through collaboration among existing regional networks, rather than concentrating these functions in a single entity. However, others are of the view that some form of dedicated regional authority would be required to adequately perform these functions. It is possible that different states will arrive at different solutions in this regard.

140 The difficulties associated with relying on a single entity have been evident in the problems encountered by PHNs, which the Commonwealth wanted to make responsible for service planning and commissioning in each of their respective networks. In their current form, PHNs do not have the requisite expertise to effectively carry out this planning, commissioning and oversight role. However, the Commonwealth government's move to require PHNs to commission services (rather than provide those services themselves) was in my view a very forward-thinking one. Such regional commissioning (when done well) can result in a much better match between the differing needs of particular regions and the nature of the services provided.

141 To address this lack of expertise, a national set of expertise templates should be developed to provide a uniform set of standards of expertise required for service planning and commissioning, not just at a national or state level, but also at a regional level. This is a topic which I expect the Productivity Commission will address in its final report (which it provided to the Commonwealth government on 30 June 2020).

<u>The importance of regionality</u>

142 Rather than focussing excessively on the debate over which forms of higher level governance may be appropriate, the key opportunity for the Royal Commission is to consider which steps could be taken now at a regional level by existing actors (such as PHNs, LHNs and other local services) in the form of region-based planning, partnerships and other forms of cooperation.

143 The answers to this question may vary from region to region. For example, in some regions (such as those lacking in private service providers and other non-government providers), it may be that the State is best placed to take a leading role in commissioning and planning. That said, I am firmly of the view that neither the Commonwealth nor state governments are equipped to bear the sole responsibility for commissioning.

Risks associated with creating new entities with a singular focus on particular objectives such as suicide prevention

144 In my view, the introduction in the early 1990s of a series of national suicide prevention initiatives, which resulted in the separation of suicide prevention from mental health at the national policy and implementation levels, was a mistake. It has contributed to a false dichotomy between suicide prevention as a non-clinical and community-based issue external to the health system, and mental health as simply a clinical or hospital-based issue.

145 This problem was acknowledged by the move in 2015 to rename the series of "National Mental Health Plans" the "National Mental Health and Suicide Prevention Plan". This was in part a recognition that the work being done in the domain of mental health had not been sufficiently coordinated with the work being done in relation to suicide prevention.

146 A similar issue has characterised the relationship between mental health and alcohol and other drug abuse. Although the latter can be a key factor in co-morbidity rates, the two policy areas have not been properly coordinated or integrated at a system planning and management level.

Co-locating system management functions with the functions related to the implementation of significant reforms

147 In my view, the dichotomy sometimes drawn between system management functions and functions related to the implementation of reforms is a false one.

148 In so far as any entity is responsible for high level systems planning and modelling, this would only require a relatively limited amount of expertise in relation to the technical aspects of reform implementation. However, at a regional level, a more sophisticated level of technical and management expertise may be required in order to be able to effectively implement changes and then monitor and respond to those changes in real time. As explained above, this expertise would also be required in order to effectively utilise the systems modelling and planning tools discussed above.

149 As discussed above, these different forms of expertise could be regulated through the promulgation of national expertise templates specifying the relevant standards of expertise required at each of the Commonwealth, State and regional levels of governance and planning.

Developments in NSW governance approaches that have empowered health service providers to deliver improved outcomes for consumers

Regional partnerships

150 The North Coast Collective is a partnership forged by the North Coast PHN in NSW and several local health districts (roughly equivalent to the Victorian LHNs). The stated vision of the Collective is to improve the way in which its partners invest in and deliver mental health care and alcohol and other drug related services in the region.

151 Although there is not yet any formal governance structure in place to oversee and coordinate the funding and commissioning of services in the region,[10] there has been a recognition that each of the individual partners have been receiving and allocating funding (from various and sometimes different government sources) in isolation without any awareness or transparency as to how other local networks within the partnership have been allocating their own funding. This lack of communication and coordination at a regional level is also reflected in the fact that many of these networks have traditionally had to compete against one another for the same limited pool of infrastructure and workforce.

152 The longer term goal of the Collective is to bring additional funding organisations into the Collective to enable the more efficient investment in mental health services in the region.

153 This underlines the need to move away from a rigid "top down" funding approach in which a wide array of separate and dislocated services and programs targeted to one specific need or purpose are funded without regard to how those services and programs might complement one another or be more effectively linked with other local services and programs.

Devolution of hospital networks

154 The State-based hospital system in NSW has devolved away from existing hospital networks in line with the national approach, based on the PHNs. This has facilitated greater cooperation and accountability among local hospitals and in my view is an improvement over the previously entirely centralised state-based approach to governance. For example, it has facilitated arrangements such as the one in South-Western Sydney between the Campbelltown Hospital and the Ramsay Hospital, to provide additional bed and clinical capacity to the public sector acute care and emergency services.

[10] The top cs of governance and comm ss on ng are cons dered n further deta ater n th s statement.

155 Although this has been a positive development for the state-based hospital system in NSW, the State is still yet to fully grapple with how it can facilitate the coordination of Commonwealth (MBS) funded services, private infrastructure, non-government services and other resources as they exist within each region.

Merits of integrating the governance arrangements of mental health and public health services at a system level

156 It has been suggested that mental health needs to have a much bigger footprint within the existing public health system, which has information systems that provide real time feedback about the effectiveness of public health services and changes in the health status of populations.

157 We do not currently have this infrastructure in mental health. To me, this will be one of the key challenges of the 21st Century: developing a robust digital monitoring capability akin to the monitoring systems that have existed for infectious diseases for the last century. This infrastructure could be built into the existing public health systems and made a priority for regional monitoring and active reporting.

Mechanisms and structures to ensure that people with lived experience have a meaningful and enduring voice in decision-making at all levels of system design, policy planning and setting, and service delivery

158 I prefer the term "lived expertise", as opposed to "lived experience", on the basis that it more accurately reflects the value people with lived expertise can add to decision-making, planning and service delivery structures in mental health. In my view, lived expertise (which should include family and carer perspectives) should be recognised as being just as essential to these structures as any other kind of expertise, whether that be legal, financial or clinical.

159 It is for this reason that lived expertise needs to be built into the governance, planning, management and service delivery structures within the mental health system. This will make the system fit for purpose: meeting the mental health needs of individuals.

160 Through my work with the National Mental Health Commission in areas such as restraint and seclusion, I have directly experienced how the input of lived expertise can shape outcomes for the better. This type of lived 'expertise' leads to a much greater focus on resolving those issues that are causing the greatest distress (very poor experiences of care) on a daily basis, and are often operating at a system level. Such issues have often been ignored by system administrators or lead clinicians.

Commissioning

Ways in which commissioning approaches can support the testing and scaling of new care models

Greater flexibility in resource allocation

161 Commissioning has introduced a degree of flexibility into a system that did not previously have any. It allows the commissioning entity to determine (or be allocated) a budget that can then be used to contract for the various services required in a given region. In this way, commissioning allows funding to support contracting against outcomes, not activity. Commissioning entities can contract for services based on need without being overly restricted by "top down" funding models.

162 This approach has been adopted, to a limited extent, in respect of certain Commonwealth supported services. For example, when I served on the Board of headspace, our services were specifically targeted at areas identified to be lacking in adequate Commonwealth (MBS) subsidised services.

163 To the extent that the State itself engages in the commissioning of services, it can also benefit from this greater flexibility. For example, the State could commission additional services in a region that is lacking capacity, rather than building the infrastructure required to provide those services itself. If the State formed the view that the services commissioned were inadequate, it could choose to contract with another provider.

164 We have already seen this in the Northern Rivers region of NSW, where the North Coast Collective eventually ended long-running contractual arrangements with existing service providers that had failed to provide services at an adequate capacity or quality and instead contracted with different service providers who it was hoped would have sufficient capacity to better meet the needs of the region.

165 This kind of flexibility can be crucial as a driver of change and accountability in service delivery and quality. Service providers can and should be contracted to achieve specific outcomes based on identified areas of need.

Data collection to enhance system responsiveness

166 Currently, many services are commissioned without any effective data collection and feedback mechanisms in place to track the progress of commissioned services in meeting the desired outcomes.

167 As noted above in relation to the need for proper utilisation of systems modelling and simulation, data collection is crucial to the effective and sustainable implementation of

system reform. If the system requires change, one needs access to data on what impact those changes have (for example, on other parts of the system).

Tendering of state-based services

168 States should give more serious consideration to tendering their own services. Interestingly, the Commonwealth government is currently commissioning state-based services, despite having not previously allowed states to tender their services in competition with one another. For example, in the youth mental health services space (headspace centres and youth intensive services), the Commonwealth has had to go back to state-based providers as they have the only substantial infrastructure, workforce and clinical governance appropriate to the task. As noted above, there needs to be a greater emphasis on considering system capacity on a national scale, rather than individual states trying to do everything on their own.

"Smart commissioning" as a means of achieving scale

169 Commissioning also serves to encourage investment in the provision of services at scale. This was a key rationale for the Commonwealth government's investment in PHNs as large scale region-based service hubs. Rather than contracting with a large number of smaller businesses or service providers to service smaller segments of the population, we should be engaging the larger private and non-government service providers that are better equipped to service larger population bases or entire regions. This is the rationale underpinning the concept of "smart commissioning".

Commissioning and service provision roles should be separate

170 At present, the prevailing view is that the commissioning entity (whichever form that entity takes) should be independent from the service providers. As noted above, this was the approach taken by the Commonwealth government with the introduction of PHNs, which are required to commission services rather than provide those services themselves.

Achieving the right balance between less centralised commissioning decision-making and government driven system planning, coordination and quality control

171 Both Commonwealth and state governments should create standardised service planning and quality control templates to drive system-wide accountability, while still allowing sufficient flexibility and autonomy at a regional level. These templates should cater for varying degrees of granularity, depending on the level at which they apply (Commonwealth, state or regional).

Consortia as a commissioning approach

172 To me, consortia as an approach to commissioning is synonymous with the collective or collaborative approach I have advocated for above in this statement.

173 In my view, too much time is spent focussing on "top down" organisational hierarchies and structures at the cost of pursuing a more collaborative approach to commissioning and systems planning, for example by empowering regional networks to utilise the systems modelling and simulation tools discussed above. By examining the full spectrum of services, infrastructure and resources available within each functional region, we can engender a stronger sense of collective responsibility across Commonwealth, state and regional players.

174 A good example of this kind of collective responsibility leading to better outcomes was the Rudd Government's approximately $2.5 billion investment in regional cancer clinics. This was a collective action, funded by the Commonwealth government and supported by states, taken to meet an identified need that had not previously been met (cancer patients in regional areas needing local access to cancer treatment). It is also a strong example of the Commonwealth government's capacity to make decisions that are region-specific, rather than simply relying on "top down" planning approaches that dictate the bulk provision of funding and resources without any regard to regional variation.

175 This kind of targeted, region-specific collective action is particularly critical given the states' lack of income flexibility. It is the Commonwealth government that controls many of the relevant funding levers; this is why the Commonwealth must be part of any long term solution pursued in Victoria.

International examples where commissioning or specific funding approaches have worked particularly well in encouraging greater coordination between service providers

176 Parts of Europe have experimented with regional approaches to commissioning and funding. Professor Luis Salvador-Carulla, now the Head of the Centre for Mental Health Research at the Australian National University, was able to implement a regional approach of this kind in a region in the Basque Country in Spain covering a population of approximately 500,000 people. This was extensively evaluated and considered a marked improvement compared to previous 'national' models.

Lessons for developing new commissioning and funding approaches in Victoria

177 There is now an established body of evidence showing that regionally planned and organised models are better at facilitating innovation and addressing the particular needs of local populations.

178 The merits of such models should not be in dispute. The real issue facing Victoria is identifying how a regional approach to planning, management and service coordination can best be implemented. As noted above, this question cannot be considered in isolation from the federal context. There must be a clear acknowledgement (by all levels of government) that the State can only offer part of the solution, not the whole solution.

Leadership

Ways in which emerging leaders can be supported and encouraged to develop the requisite capabilities and skills

Encouraging creativity and innovation

179 We need to create an environment that is conducive to creativity and innovation. When I began my career as a psychiatrist in the 1970s, the pursuit of working in the community and assuming community and clinical leadership roles was actively encouraged in the profession; it was seen as a very progressive thing to do. This was partly because the mental health system (in its nascent form at the time) was undergoing great change; there was widespread acceptance that the existing asylum model was no longer fit for purpose. I was fortunate at this time that experimentation and community engagement was strongly encouraged in junior members of the profession by senior clinical leaders.

180 Since then, the system has somewhat stultified the personal drive in individuals to engage in innovation and development. While there are similar problems in other areas of public, academic and clinical medicine, psychiatry has been much harder hit. A retreat to a very hospital-based and institutional framework has been a key driver of this phenomenon.

181 One means of remedying this would be to offer individuals greater autonomy, at a local level, to innovate and drive change, for example by engaging with their own service provider or institution. This could be achieved through multi-disciplinary and community-based mentoring and learning and development programs. Such programs would need to be able to expose participants to the experience of being actively involved in effecting change at a local level.

De-politicising leadership in mental health

182 In order to de-politicise the topic of mental health, there must be a strong focus on the development of skills in evidence gathering and systematic evaluation. Rather than simply offering a solution, people should be encouraged to demonstrate a sound evidentiary basis for reaching a given conclusion.

183 There are various structures that could be put in place to facilitate and encourage this form of evidence-based thinking, research and innovation. The leadership programs offered at the Brain and Mind Centre are one example of this.

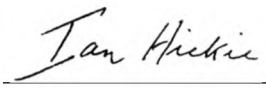
Additional State funding and support for health services research

184 Academic research into systems planning and design is key to identifying new innovations and ideas that may be worthy of further exploration and investment. Evidence-based research can also play a key role in improving system monitoring and responsiveness by testing and evaluating system reforms. Dynamic systems modelling and related simulation tools (of the kind discussed above at paragraphs [131] to [138]) are key enablers of this type of work.

The post COVID-19 era and the importance of collective action

185 The destabilisation and disorientation that has resulted from the COVID-19 pandemic has brought us to an interesting juncture. It has highlighted the limitations of the federal system of government in Australia. It has also demonstrated the importance of collective responsibility and action. The virus has shown in a very real way how we are all affected by the behaviour of one another. As terrible as the impacts of the pandemic have been, it has engendered a new spirit of cooperation.

186 As we emerge from the current crisis, the ultimate question will be whether we are capable of achieving collective and coordinated action in a way that can be sustained beyond the immediate crisis.

sign here ▶ 

print name Ian Hickie

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Royal Commission into
Victoria's Mental Health System

ATTACHMENT IH-1

This is the attachment marked 'Attachment IH-1' referred to in the witness statement of Ian Hickie dated 11 August 2020.

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Career Overview

Last updated: June 2020

Professor Hickie is currently an NHMRC Senior Principal Research Fellow (2018-2022) (previously an NHMRC Australian Research Fellow, 2007-2012), a Fellow of the Academy of Social Sciences in Australia (FASSA), a Fellow of the Royal Australian & New Zealand College of Psychiatrists (FRANZCP), A Member of the Order of Australia (AM), a Doctor of Medicine (MD, UNSW, 1990), a Professor of Psychiatry at Sydney Medical School (University of Sydney, 2003-) and the Executive Director of the Brain & Mind Research Institute, University of Sydney (2003-2014). In 2015 he became a fellow of the new Australian Academy of Health and Medical Sciences. From 2012, Professor Hickie was appointed as one of Australia's first National Mental Health Commissioners and was reappointed to a second term in that role in 2014 which ended in July 2018.

Professor Hickie is recognised nationally for his role over the last two decades in using clinical, health services and population health data to drive innovations in health services in mental health policy, particularly enhanced mental health awareness, primary care services and increased access to psychological treatments. As the inaugural CEO of beyondblue: the national depression initiative, he led the development of this major national organisation and developed its implementation and evaluation strategies.

Professor Hickie's work in linking community understanding to population health and health services developments for those affected by common anxiety and depressive disorders is recognised internationally. This is evident through his participation and leadership roles in international networks and initiatives, including notably those in the Asia-Pacific Region. The focus of this work lies in recognizing the contribution that common mental health problems play to non-participation in education, employment and broader forms of social participation.

In Australia, Professor Hickie has participated in each of the major national advisory bodies on mental health to the Federal Health Minister or Prime Minister since 2007. He has worked with the Mental Health Council of Australia since 2001 to advance national mental health policy and practice. In partnership with the Mental Health Council of

Australia, the Human Rights and Equal Opportunities Commission, Orygen Youth Health, the Young & Well CRC and the National Mental Health Commission, he has authored major national reports on the evaluation or delivery of the community experiences of mental health services and the impacts of various mental health initiatives.

Over the last decade, Professor Hickie has worked in close partnership with Professor Pat McGorry at the forefront of development and evaluation of the new primary-care based youth mental health services (headspace: the national youth mental health foundation). He has also been a critical voice in the advocacy for enhanced social as well as better health services for those with persistent mental illness and increased accountability for delivery of those services. Concurrently, he has worked closely with Assoc Professor Jane Burns, in partnership with the Inspire Foundation to develop e-mental health initiatives, resulting in the $27M Young & Well Co-operative Research Centre (2011-2016), of which Professor Hickie is the Chair of the Scientific Advisory Council. This initiative has now led to the further investment of $30m over the next three years by the Turnbull Government to develop Project Synergy as the central digital architecture for mental health services delivery in the online environment.

The success of each of these national initiatives was recognised in the 2011 Australian Budget, which devoted $2.2 billion (over five years) to new mental health services (including over $400m to new youth services and expansion of the headspace services to 90 sites nationally) and also prioritised e-health developments, mental health research and established the new National Mental Health Commission. These developments were further enhanced by the 2014 national budget announcements which devoted a further $18m to a national centre of youth mental health and $5m to development of e-mental health integration led by the Young & Well CRC.

From a specialist psychiatrist perspective, Professor Hickie has focused on using new technologies (structural and functional neuroimaging, immune markers, circadian measurements) to assist with the delineation of novel pathways to depression and other mood disorders. This work has emphasised the role of genetic (stress-sensitivity, disturbed circadian systems) and environmental factors (e.g. alcohol and other substance misuse, dysfunctional relationships, infective illness and disturbed sleep patterns) and vascular disease in older persons.

Internationally, Professor Hickie is recognised for his novel work in the post-infective neuropsychiatric disorders (persistent fatigue states), the delineation of the relevance of sub-cortical vascular disease to onset and course of depression in the elderly, his leadership of population-based approaches to changing attitudes to mental health (particularly depression) and his role in increasing investments in new services (particularly youth services and new e-mental health structures). His previous input into Centers of Disease Control (USA) and NIH consensus statements are evidence of this impact.

In partnership with Professor McGorry, he has developed a novel clinical staging framework for emerging and severe mental disorders in young people. He has led the establishment of large clinical cohorts focused on the emerging mood disorders and promoted other national epidemiological and longitudinal studies to examine the emergence of mood disorders in the wider population. He is a key member of novel international family and longitudinal studies designed to answer similar questions. His current programs with the Genetic Epidemiology Branch of the NIMH are evidence of his ongoing contributions in the delineation of risk factors for and pathways to the onset of major mood disorders.

Professor Hickie's leadership (CIA) of the new NHMRC Centre of Research Excellence (Clinical) for Optimizing the treatment of emerging mood disorders in young people (2014-2018) is evidence of his capacity to coordinate and lead major new projects to enhance Australia's capacity to respond to young people with disabling mental health problems. Similarly, his key role in the NHMRC CRE for Suicide Prevention (2013-2017, CIA Professor Helen Christensen) is evidence of his capacity to work effectively with major new national population-focused initiatives in mental health.

As of November 2016, he has published over 560 peer-reviewed papers, and according to Scopus has an h-factor of 66, based on 19 206 citations; Web of Science has 593 recognised reports, 16116 citations, 27.2 citations per work and an h-index of 61. Google Scholar (incorporating more of his reports to non-scientific and other agencies) notes 28,815, citations and a h-index of 79.

Professional Career Development

In 1993-1994, Professor Hickie was a Harkness Fellow of the Commonwealth Fund of New York and an Associate Professor at Duke University North Carolina. On returning to Australia, in 1995 he established the Academic Department of Psychiatry at St George Hospital Sydney. In 1997, he was appointed Professor of Community Psychiatry at the University of NSW.

From 2000 to 2003, Professor Hickie was the inaugural CEO of beyondblue: the national depression initiative, and from 2003 to 2006, he was the clinical advisor to this national organisation. In his role at beyondblue, he established the major awareness, prevention and early intervention programs, infrastructure, consumer and carer participation organisations, national community and primary care partnerships, large and small grants mechanisms and evaluative processes, which have underpinned the internationally-recognised work of the organisation. The impact of beyondblue has been assessed systematically by both internal and external agencies. It demonstrates that a well-coordinated, community-led and clinically-informed health agency can have a major positive impact.

While a Board Member of the Mental Health Council of Australia, Professor Hickie was at the forefront of national movements to assess consumers' and carers' experiences of mental health services. These activities have resulted in key publications such as the 2002 report "Out of Hospital, Out of Mind!", the 2004 pre-election policy document "Investing in Australia's Future" and the 2005 report in partnership with the Human Rights and Equal Opportunities Commission "Not for Service". These reports assisted to focus national attention on the need to reshape mental health services to concentrate on the needs of youth and commit to key social, educational and economic outcomes. They were fundamental to the COAG agreement of 2006-2011 which resulted in an additional $5.5b expenditure in mental health and the introduction of access to psychological services within the broad Medicare Scheme.

From 2008-2011, Professor Hickie served on the National Advisory Council on Mental Health reporting to the Federal Minister of Health and Aging. In 2011 he was appointed to the Mental Health Expert Advisory Group to the Minister for Mental Health and the Prime Minister. From 2007-2010, he served on the Australian National Council on Drugs.

Professor Ian Hickie was appointed in 2003 as the inaugural Executive Director of the Brain and Mind Centre (formally BMRI) at The University of Sydney and in 2015 was appointment as the Co-Director, Health and Policy. The Brain and Mind Centre has received extensive support from the Australian Government and the NSW Government to develop research, training and clinical services infrastructure devoted to the reduction of the national health burden due to psychiatric and neurological disorders, particularly amongst young persons. This forms part of the $85 million redevelopment program being funded by The University of Sydney and governmental and private partners.

Professor Hickie has been a member of the NHMRC Program grants (2005-2009; 2009-2013) led by Professor McGorry. These focus on the evaluation of clinical interventions in order to reduce the health burden among young persons with severe mental illness. The Brain and Mind Centre serves as the Sydney base for these major national research, education and training programs. Additionally, these groups were selected to lead headspace: the National Youth Mental Health Foundation.

In 2005, Professor Hickie was awarded the Margaret Tobin Award of the Royal Australian and New Zealand College of Psychiatrists, which recognises the Fellow of the College who has made the most significant contribution to Administrative Psychiatry in Australia or New Zealand during the last five years. In 2006, Professor Hickie received the Australian Honours Award of Member (AM) in the General Division for services to medicine in the development of key national mental health initiatives and general practice services in both the public and non-government sectors. In 2009, he received the Research Australia Advocacy Award for his work in mental health advocacy. In 2014, he received the Founders Medal of the Society for Mental Health Research (SMHR, formerly ASPR), recognising his lifetime contribution to mental health research in Australasia.

In 2006, the Australian Financial Review, ranked Professor Hickie as one of Australia's top 10 cultural influences,

due to his role in initiating the 2006-2011 COAG reforms and investments in mental health. The Factiva data-base of news stories notes that during 2007-2011, Professor Hickie appeared on 790 occasions in media stories about mental health, brain health and general health reform.

From 2007-2012, Professor Hickie was one of the first NHMRC Australian Fellows; recognising excellence in Australian Medical Research. This facet of his work focused on expansion of population-based mental health research and development of international mental health strategies.

Since returning to full-time academia in 2004, after being CEO of beyondblue, Professor Hickie has received over $37m in NHMRC competitive grant funding. This comprises an Australian fellowship (464914); a Senior Principal Research Fellowship (1046899); two program grants (566529 and 350241); a CCRE grant (264611); two CRE grants (1042580 and 1061043); a TCR in Mental Health Research (1042666); a partnership grant (1076940); as well as major project grants (notably, 301930, 1060397, 1069141 and 1086683). Further to this, he has attracted $732,434 in ARC grant funding (LP0883035 and LP13010045). Professor Hickie has attracted more than $5,000,000 in specific national youth health services grants ($5,400,000 for headspace population health) and $2,000,000 in recurrent annual funding from 2012 onwards. Professor Hickie and the Brain and Mind Centre (formally BMRI) are essential partners to the new $27,647,000 CRC for Young People, Technology and Wellbeing. Other funding has included NSW Government ($600,150 for drug and alcohol services), $1,899,198 from other non-government funding bodies such as the National Heart Foundation, beyondblue: the national depression initiative, the Cancer Council of Australia and the Bupa Health Foundation, and $431,000 from pharmaceutical industry-supported research.

Academic & Professional Qualifications

1982:	Bachelor of Medicine, Bachelor of Surgery, University of New South Wales. Honours Degree, Second Class, First Division.
1989:	Fellow of the Royal Australian and New Zealand College of Psychiatrists.
1990:	Doctor of Medicine (MD), University of New South Wales. "Interpersonal relationships and depressive disorders".

Career Details

2003- 2015:	Executive Director, Brain & Mind Research Institute, The University of Sydney.
2003	Professor of Psychiatry, Sydney Medical School, The University of Sydney.
2015	Co-Director, Health and Policy, Brain and Mind Centre (formally BMRI), The University of Sydney.
2000 - 2003:	Chief Executive Officer, *beyondblue: the national depression initiative,* Hawthorn, Victoria.
1997 - 2003:	Professor of Community Psychiatry, School of Psychiatry, University of New South Wales.
1995 - 2000:	Director, Academic Department of Psychiatry, St George Hospital and Community Health Service, Kogarah.
1994 - 1996:	Associate Professor of Psychiatry, School of Psychiatry, University of New South Wales.
1994:	Visiting Associate Professor, Department of Psychiatry, Duke University Medical Center, Durham, North Carolina.
1993 - 1994:	Harkness Fellow of the Commonwealth Fund of New York.
1991 - 1993:	Senior Lecturer in Psychiatry, School of Psychiatry, University of New South Wales.
1989 - 1991:	Staff Specialist in Psychiatry, Prince Henry Hospital.
1987 - 1989:	Research Fellow in Psychiatry, New South Wales Institute of Psychiatry.
1984 - 1987:	Registrar in Psychiatry, Prince of Wales and Prince Henry Hospital.
1982 - 1983:	Resident Medical Officer, Westmead Hospital.

Prizes, Fellowships & Awards

2015: Fellow, Australian Academy of Health and Medical Sciences
2014: Society for Mental Health Research, Founders Medal
2009: National Research Advocacy Award, Research Australia
2007: Fellow, Australian Academy of Social Sciences
2007: NHMRC 2008 Australian Fellowship; for the expansion of population-based mental health research and further development of international mental health strategies
2006: Australian Honours Award of Member (AM) in the General Division; for services to medicine in the development of key national mental health initiatives and general practice services in both the public and non-government sectors.
2005: Royal Australian and New Zealand College of Psychiatrists: Margaret Tobin Award for the Fellow who has made the most significant contribution to administrative psychiatry in Australia and New Zealand in the last five years.
1999: THEMHS: Gold Award Winner – Individual or team award for an outstanding contribution to theory, education or practice. THEMHS Conference, Melbourne.
1998: Australian Society for Psychiatric Research: Novartis Oration. ASPR Conference.
1997: Royal Australian and New Zealand College of Psychiatrists: Organon Senior Research Award.
1993: Harkness Fellow of the Commonwealth Fund of New York.
1992: Royal Australian and New Zealand College of Psychiatrists: Organon Junior Research Award.
1990: Australian Society for Psychiatric Research: Organon Research Prize. ASPR Conference.
1989: Maddison Medal for achievement in examinations for admission to the Royal Australian and New Zealand College of Psychiatrists.
1987: Research Fellowship, New South Wales Institute of Psychiatry.

PROFESSIONAL EXECUTIVE & COMMITTEE RESPONSIBILITIES

2018: Member, Improved Models of Care Working Group of the Private Health Ministerial Advisory Committee.
2017: Member, The Society for Mental Health Research Executive, NSW Representative.
2014- 2017: Member, Medical Advisory Panel, Medibank Private.
2012 – 2018: Commissioner, Australian Government National Mental Health Commission.
2010 – 2011: Member, Access to Allied Psychological Services (ATAPS) Advisory Committee, Department of Health and Ageing.
2011: Member, Department of Defence Mental Health Advisory Group
2011: Trustee, Psychosis Australia Trust
2011: Member, Mental Health Expert Working Group (MHEWG), Department of Health and Ageing.
2009 – 2013: Member, Bupa Australia Medical Advisory Panel.
2009: Research Australia: Advocacy Award for Work in Mental Health.
2009: Director of Headspace National Youth Mental Health Foundation LTD.
2009: Member, Common Approach to Assessment Referral and System Taskforce which is co-convened by the Minister for Families, Housing, Community Services and Indigenous Affairs and ARACY.
2008 – 2011: Member, National Advisory Council on Mental Health to the Federal Minister of Health and Ageing.
2007 - 2011: Board Member, Australian National Council on Drugs.
2007 - 2008: Board Member of AFFIRM: The Australian Foundation for Mental Health Research.
2005 - 2009: Member of the Foundation Executive Committee for the National Youth Mental Health Foundation.
2004: Mental Health Representative, National Chronic Diseases Strategy, Expert Advisory Group, Dept. of Health and Ageing, Australian Government.
2003 – 2006: Co-opted Board Member for Research, Mental Health Council of Australia.
2003 – 2006: Chief Operating Officer, Reducing the Socio-Economic Burden of Depression in Asia (SEBoD) Initiative.
2003 - 2006: Clinical Advisor, *beyondblue: the national depression initiative*, Hawthorn, Victoria.
2003: Visiting Fellow, Centre for Mental Health Research, Australian National University.
2003: Member, Writing Group for preparation of report on Neurosciences and Mental Health to Prime Minister's Science, Engineering and Innovation Council.
2003: Member of Executive, Brain & Mind Australia.

2003 - 2006: Board member (co-opted for research), *Mental Health Council of Australia.*
2003 - 2006: Member, Board of Research, ORYGEN Youth Health Initiative.
2001 - 2003: Chair, Expert Advisory Group, Victorian Centre of Excellence for Depression and Related Disorders.
2002: Chair, Evaluation Advisory Group, *Better Outcomes in Mental Health*, Dept Health and Ageing, Australian Government.
2002: Chair, Advisory Group on Mental Health, *National Health Priorities Area Action Council,* Dept Health and Ageing, Australian Government.
2002: Member, Implementation Advisory Group for *Better Outcomes in Mental Health*, Dept Health and Ageing, Australian Government.
2001 - 2003: Clinical Practice Guideline Team for Treatment of Depression (Commissioned by the Australian Federal Dept. of Health and Ageing).
2001 - 2002: Co-Chair Committee for Incentives for Mental Health, Dept. of Health and Ageing, Australian Government.
2000 - 2003: Board member, *beyondblue: the national depression initiative.*
1998 - 2002: Director, National Secretariat, 'SPHERE: A National Depression Project'.
1997 - Advisory Board, Royal Australian and New Zealand Journal of Psychiatry.
1996 - 2002: Member, Working Party for Clinical Practice Guidelines for CFS, Royal Australasian College of Physicians.
1996: Member, Primary Care Working Party, New South Wales Centre for Mental Health.
1996: Chairman, Acute Care Working Party, New South Wales Centre for Mental Health Policy.
1995 - 1997: Area Executive, South-Eastern Sydney Area Mental Health Services.
1995 - 1997: Executive, Board of Medical Studies, St George Hospital and Community Health Service.
1995 - 2000: Member, Executive, Division of Psychiatry, St George Hospital and Community Health.
1993 - 1994: Member, Chronic Fatigue Syndrome, International Research Group.
1992 - 1993: Treasurer, Biological Psychiatry Section Australian Society for Psychiatric
1990 - 1993: Member, Committee for Postgraduate Training, New South Wales Branch, Royal Australian and New Zealand College of Psychiatrists.
1989 - 1992: Chairman, Postgraduate Training Committee, RANZCP, South-eastern Zone of Sydney.

Publications in Peer-Review Journals

1. Park, S. H., Song, Y. J. C., Demetriou, E. A., Pepper, K. L., Thomas, E. E., **Hickie, I. B.**, & Guastella, A. J. (2020). Validation of the 21-Item Depression, Anxiety, and Stress Scales (DASS-21) in individuals with Autism Spectrum Disorder. *Psychiatry Research*, 113300.
2. Demetriou, E.A., Park, S.H., Ho, N., Pepper, K.L., Song, Y.J., Naismith, S.L., Thomas, E.E., **Hickie, I.B**. and Guastella, A.J., 2020. Machine Learning for Differential Diagnosis Between Clinical Conditions With Social Difficulty: Autism Spectrum Disorder, Early Psychosis, and Social Anxiety Disorder. *Frontiers in Psychiatry*, *11*, p.545.
3. Hagenaars, S. P., Coleman, J., Choi, S. W., Gaspar, H., Adams, M. J., Howard, D. M., Hodgson, K., Traylor, M., Air, T. M., Andlauer, T., Arolt, V., Baune, B. T., Binder, E. B., Blackwood, D., Boomsma, D. I., Campbell, A., Cearns, M., Czamara, D., Dannlowski, U., Domschke, K., ... Lewis, C. M. (2020). Genetic comorbidity between major depression and cardio-metabolic traits, stratified by age at onset of major depression. *American journal of medical genetics. Part B, Neuropsychiatric genetics : the official publication of the International Society of Psychiatric Genetics*, 10.1002/ajmg.b.32807. Advance online publication. https://doi.org/10.1002/ajmg.b.32807
4. Rohleder, C., Song, Y.J.C., Crouse, J.J., Davenport, T.A., Iorfino, F., Hamilton, B., Zmicerevska, N., Nichles, A., Carpenter, J.S., Tickell, A.M.,... Wilson, C., 2020. Youth Mental Health Tracker: protocol to establish a longitudinal cohort and research database for young people attending Australian mental health services. *BMJ Open*, 10(6), p.e035379.
5. Berger, M., Nelson, B., Markulev, C., Yuen, H. P., Schäfer, M. R., Mossaheb, N., Schlögelhofer, M., Smesny, S., Hickie, I. B., Berger, G. E., Chen, E., de Haan, L., Nieman, D. H., Nordentoft, M., Riecher-Rössler, A., Verma, S., Mitchell, T. W., Meyer, B. J., Thompson, A., Yung, A. R., ... Amminger, G. P. (2020). Corrigendum: Relationship

Between Polyunsaturated Fatty Acids and Psychopathology in the NEURAPRO Clinical Trial. *Frontiers in psychiatry*, *11*, 514. https://doi.org/10.3389/fpsyt.2020.00514

6. Atkinson JA, Skinner A, Lawson K, Rosenberg S, **Hickie IB**. Bringing new tools, a regional focus, resource-sensitivity, local engagement and necessary discipline to mental health policy and planning. *BMC Public Health*. 2020; 20(1):814. Published 2020 Jun 5. doi:10.1186/s12889-020-08948-3
7. Chanen, A., Yung, A., Killackey, E., **Hickie, I.**, Coghill, D., Scott, J. G., ... & Kane, J. (2020). The value of early intervention in creating the new mental health system: Response to Allison et al [published online ahead of print, 2020 May 28]. *Aust N Z J Psychiatry*. 2020; 4867420925169. doi:10.1177/0004867420925169
8. Opel, N., Thalamuthu, A., Milaneschi, Y., Grotegerd, D., Flint, C., Leenings, R., ... & Berger, K. (2020). Brain structural abnormalities in obesity: relation to age, genetic risk, and common psychiatric disorders. *Molecular Psychiatry*, 1-14.
9. Rosenberg S, Salvador-Carulla L, **Hickie I**, Mendoza J. Stepped mental health care model leading Australia astray [published online ahead of print, 2020 May 29]. *Australas Psychiatry*. 2020;1039856220928858. doi:10.1177/1039856220928858
10. Shah, J.L., Scott, J., McGorry, P.D., Cross, S.P., Keshavan, M.S., Nelson, B., Wood, S.J., Marwaha, S., Yung, A.R., Scott, E.M., Öngür, D., Conus, P., Henry, C., **Hickie, I.B.** and (2020), Transdiagnostic clinical staging in youth mental health: a first international consensus statement. *World Psychiatry*, 19: 233-242. doi:10.1002/wps.20745
11. Han, L.K.M., Dinga, R., Hahn, T. *et al.* Brain aging in major depressive disorder: results from the ENIGMA major depressive disorder working group. *Mol Psychiatry* (2020).https://doi.org/10.1038/s41380-020-0754-0
12. Byrne, E.M., Kirk, K.M., Medland, S.E., McGrath, J.J., Colodro-Conde, L., Parker, R., Cross, S., Sullivan, L., Statham, D.J., Levinson, D.F., Licinio, J., Wray, N.R., **Hickie I.B**. and Martin, N.G. (2020). Cohort profile: the Australian genetics of depression study. *BMJ Open*, *10*(5), p.e032580.
13. Roughan, W. H., Campos, A. I., Garcia-Marin, L. M., Cuellar-Partida, G., Lupton, M. K., **Hickie, I. B.**, ... & Martin, N. G. (2020). Pharmacoepidemiology of comorbid chronic pain and depression: Insights from a case-control study. *medRxiv*.
14. Campos, A. I., Thompson, P. M., Veltman, D. J., Pozzi, E., van Veltzen, L. S., Jahanshad, N., ... & Connolly, C. G. (2020). Brain correlates of suicide attempt in 18,925 participants across 18 international cohorts. *medRxiv*.
15. Byrne, E. M., Henders, A. K., **Hickie, I. B.**, Middeldorp, C. M., & Wray, N. R. (2020). Nick Martin and the Genetics of Depression: Sample Size, Sample Size, Sample Size. *Twin Research and Human Genetics*, 1-3.
16. Hoyos, C. M., Gordon, C., Terpening, Z., Norrie, L., Lewis, S. J., **Hickie, I. B.**, & Naismith, S. L. (2020). Circadian rhythm and sleep alterations in older people with lifetime depression: a case-control study. *BMC psychiatry*, *20*(1), 1-9.
17. Hadar H, Zhang H, Phillips LJ, Amminger GP, Berger GE, Chen EYH, de Haan L, Hartmann JA, **Hickie IB**, Lavoie S, Markulev C, McGorry PD, Mossaheb N, Nieman DH, Nordentoft M, Riecher-Rössler A, Schäfer MR, Schlögelhofer M, Smesny S, Thompson A, Verma S, Yuen HP, Yung AR, Nelson B. Do schizotypal or borderline personality disorders predict onset of psychotic disorder or persistent attenuated psychotic symptoms in patients at high clinical risk? *Schizophr Res*. 2020 Apr 15. pii: S0920-9964(20)30176-6. Doi: 10.1016/j.schres.2020.03.065.
18. Rowe, S. C., Davenport, T. A., Easton, M. A., Jackson, T. A., Melsness, J., Ottavio, A., & **Hickie AM, I. B**. (2020). Co-designing the InnoWell Platform to deliver the right mental health care first time to regional youth. *Australian Journal of Rural Health*.
19. Carpenter JS, Iorfino F, Cross S, Nichles A, Zmicerevska N, Crouse JJ, Palmer JR, Whitton AE, White D, Naismith SL, Guastella AJ, Hermens DF, Scott J, Scott EM, **Hickie IB**. Cohort profile: the Brain and Mind Centre Optymise cohort: tracking multidimensional outcomes in young people presenting for mental healthcare. *BMJ Open*. 2020 Mar 29;10(3):e030985. doi: 10.1136/bmjopen-2019-030985.
20. Crouse JJ, Chitty KM, Iorfino F, Carpenter JS, White D, Nichles A, Zmicerevska N, Tickell AM, Lee RSC, Naismith SL, Scott EM, Scott J, Hermens DF, **Hickie IB**. Transdiagnostic neurocognitive subgroups and functional course in young people with emerging mental disorders: a cohort study. *BJPsych Open*. 2020 Mar 19;6(2):e31. doi: 10.1192/bjo.2020.12.
21. Mallawaarachchi SR, Amminger GP, Farhall J, Bolt LK, Nelson B, Yuen HP, McGorry PD, Markulev C, Schäfer MR, Mossaheb N, Schlögelhofer M, Smesny S, **Hickie IB**, Berger GE, Chen EYH, de Haan L, Nieman DH, Nordentoft M, Riecher-Rössler A, Verma S, Thompson A, Yung AR, Allott KA. Cognitive functioning in ultra-high risk for psychosis individuals with and without depression: Secondary analysis of findings from the NEURAPRO randomized clinical trial. *Schizophr Res*. 2020 Mar 11. pii: S0920-9964(20)30111-0. doi:

10.1016/j.schres.2020.03.008.
22. Vallerga CL, Zhang F, Fowdar J, McRae AF, Qi T, Nabais MF, Zhang Q, Kassam I, Henders AK, Wallace L, Montgomery G, Chuang YH, Horvath S, Ritz B, Halliday G, **Hickie I**, Kwok JB, Pearson J, Pitcher T, Kennedy M, Bentley SR, Silburn PA, Yang J, Wray NR, Lewis SJG, Anderson T, Dalrymple-Alford J, Mellick GD, Visscher PM, Gratten J. Analysis of DNA methylation associates the cystine-glutamate antiporter SLC7A11 with risk of Parkinson's disease. *Nat Commun*. 2020 Mar 6;11(1):1238. doi: 10.1038/s41467-020-15065-7.
23. Rosenberg S, **Hickie I**. W(h)ither psychiatry? Contemporary challenges in Australian mental health workforce design. *Australas Psychiatry*. 2020 Feb 24:1039856220905300. doi: 10.1177/1039856220905300.
24. Crouse JJ, Chitty KM, Iorfino F, Carpenter JS, White D, Nichles A, Zmicerevska N, Guastella AJ, Scott EM, Lee RSC, Naismith SL, Scott J, Hermens DF, **Hickie IB**. Modelling associations between neurocognition and functional course in young people with emerging mental disorders: a longitudinal cohort study. *Transl Psychiatry*. 2020 Jan 21;10(1):22. doi: 10.1038/s41398-020-0726-9.
25. DeMayo, M., Pokorski, I., Song, Y.J.C., Thapa, R., Patel, S., Ambarchi, Z., Soligo, D., Sadeli, I., Thomas, E.E., **Hickie, I.B**. and Guastella, A.J., 2020. The feasibility of Magnetic Resonance Imaging in a non-selective comprehensive clinical trial in pediatric Autism Spectrum Disorder. (Preprint)
26. Scott J, Martin NG, Parker R, Couvy-Duchesne B, Medland SE, **Hickie I**. Prevalence of self-reported subthreshold phenotypes of major mental disorders and their association with functional impairment, treatment and full-threshold syndromes in a community-residing cohort of young adults. *Early Interv Psychiatry*. 2020 Feb 12. doi: 10.1111/eip.12942.
27. Ospina-Pinillos L, Davenport TA, Navarro-Mancilla AA, Cheng VWS, Cardozo Alarcón AC, Rangel AM, Rueda-Jaimes GE, Gomez-Restrepo C, **Hickie IB**. Involving End Users in Adapting a Spanish Version of a Web-Based Mental Health Clinic for Young People in Colombia: Exploratory Study Using Participatory Design Methodologies. *JMIR Ment Health*. 2020 Feb 8;7(2):e15914. doi: 10.2196/15914.
28. Mei C, Fitzsimons J, Allen N, Alvarez-Jimenez M, Amminger GP, Browne V, Cannon M, Davis M, Dooley B, **Hickie IB**, Iyer S, Killackey E, Malla A, Manion I, Mathias S, Pennell K, Purcell R, Rickwood D, Singh SP, Wood SJ, Yung A, McGorry PD. Global research priorities for youth mental health. *Early Interv Psychiatry*. 2020 Feb;14(1):3-13. doi: 10.1111/eip.12878.
29. Park SH, Song YJC, Demetriou EA, Pepper KL, **Hickie IB**, Glozier N, Hermens DF, Scott EM, Guastella AJ. Distress, quality of life and disability in treatment-seeking young adults with social anxiety disorder. *Early Interv Psychiatry*. 2020 Jan 16. doi: 10.1111/eip.12910.
30. **Hickie IB**. The role of new technologies in monitoring the evolution of psychopathology and providing measurement-based care in young people. *World Psychiatry*. 2020 Feb;19(1):38-39. doi: 10.1002/wps.20697.
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Other Published Work

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20. **Hickie I**. What is depression? [patient handout]. *Australian Doctor*, Suppl (June 21).
21. **Hickie I**, Blashki G. (2002) A review of "Treating depression: the *beyondblue* guidelines for treating depression in primary care" (by P.M. Ellis and D.A.R. Smith, published in The Medical Journal of Australia 2002, 176 Suppl (May 20): S77-S83). *Australian Doctor*, Suppl (June 21).
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47. Wilson A, **Hickie I**. (1994) The treatment of chronic fatigue syndrome: current perspectives. *Focus on Depression and Anxiety*, 5: 11-16.
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50. **Hickie IB**, Wakefield D. (1992) Diagnosing CFS: principles and pitfalls for the patient, physician and researcher. *The Chronic Fatigue and Immune Dysfunction Syndrome Chronicle*, September: 35-41.
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2. Mental Health Council of Australia. (2005) *"Not for Service": Experiences of Injustice and Despair in Mental Health Care in Australia*. Canberra.
3. **Hickie I**, Groom G, Davenport T. (2004) *Investing in Australia's Future: the personal, social and economic benefits of good mental health*.

4. Read L, Mendelson F, Bennett M, Byrne E, **Hickie I**, Jablensky A, Pantelis C, Schofield P. (2003) *Brain and mind disorders: impact of the neurosciences*. PMSEIC Report.
5. Groom G, **Hickie I**, Davenport T. (2003) '*OUT OF HOSPITAL, OUT OF MIND!' A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy in 2003-2008*. Canberra: Mental Health Council of Australia.
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7. **Hickie I**. (1988) *Interpersonal relationships in depressive disorders*. RANZCP dissertation.

Educational Materials

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2. **Hickie I**, Scott E. (2002) '*SPHERE: a national depression project'. Depression and anxiety: an introductory training program for general practitioners*. Seminar 3 (CD-Rom). Melbourne: Educational Health Solutions.
3. **Hickie I**, Scott E. (2002) '*SPHERE: a national depression project'. Depression and anxiety: an introductory training program for general practitioners*. Seminar 2 (CD-Rom). Melbourne: Educational Health Solutions.
4. **Hickie I**, Scott E. (2002) '*SPHERE: a national depression project'. Depression and anxiety: an introductory training program for general practitioners*. Seminar 1 (CD-Rom). Melbourne: Educational Health Solutions.
5. **Hickie I**, Scott E, Davenport T, Ricci C, Hadzi-Pavlovic D, Morgan H, Sumich S. (2002) *Depression and anxiety: an introductory training program for general practitioners. Guide for facilitators*. Melbourne: Educational Health Solutions.
6. Scott E, Pesiah C, **Hickie I**, Ricci C, Davenport T. (2002) *Mental health in late-life: a training program for general practitioners*. Melbourne: Educational Health Solutions. ISBN No. 0-9578376-4-X.
7. **Hickie I**, Scott E, Davenport T, Ricci C, Hadzi-Pavlovic D, Morgan H, Sumich S. (2002) *Treating depression and anxiety: a training manual for general practitioners*. Melbourne: Educational Health Solutions. ISBN No. 0-9578376-3-1.
8. Scott E, Davenport T, Gillies K, Buist A, **Hickie I**. (2002) *Women's health and depression*. Melbourne: Educational Health Solutions. ISBN No. 0-9578376-2-3.
9. **Hickie I**. (2000) *SPHERE: neurasthenia (Chinese version)*. Melbourne: Educational Health Solutions (video-tape).
10. **Hickie I**. (2000) *SPHERE: neurasthenia*. Melbourne: Educational Health Solutions (video-tape).
11. **Hickie I**. (2000) *SPHERE: depression in the medically ill*. Melbourne: Educational Health Solutions (video-tape).
12. **Hickie I**, Scott E, Barton D. (2000) *Depression in the medically ill*. Melbourne: Educational Health Solutions. ISBN No. 0-9587280-9-7.
13. Morgan H, Sumich H, **Hickie I**, Naismith S, Gander J, Scott E, Davenport T. (2001) *Structured problem solving for depression*. Melbourne: Educational Health Solutions. ISBN No. 0-9578376-1-5.
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17. **Hickie I**, Scott E, Morgan H, Sumich H, Naismith S, Davenport T, Hadzi-Pavlovic D, Gander J. (2000) *A depression management program for young people and their general practitioners*. Melbourne: Educational Health Solutions. ISBN No. 0-9587280-8-9.
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20. **Hickie I**. (2000) *SPHERE: Implementation of NHMRC guidelines for the management of depression in young people*. Melbourne: Entreg Pty Ltd (video-tape).
21. **Hickie I**. (2000) *Cultural awareness*. Melbourne: Entreg Pty Ltd (video-tape).
22. **Hickie I**. (2000) *SPHERE: Cognitive behavioural therapy*. Melbourne: Entreg Pty Ltd (video-tape).
23. **Hickie I**. (1999) *SPHERE: setting the scene*. Melbourne: Entreg Pty Ltd (video-tape).
24. **Hickie I**. (1999) *SPHERE 1998: year in review*. Sydney: Educational Health Solutions (audio-tape).
25. **Hickie I**. (1998) *Introduction to SPHERE Project/Introduction to case-identification*. Sydney: Educational Health Solutions (audio-tape).
26. **Hickie I**, Scott E, Ricci C, Hadzi-Pavlovic D, Davenport T, Naismith S, Koschera A. (1998) *Treating depression and anxiety in general practice: training manual*. Sydney: Educational Health Solutions. ISBN No. 0-9587280-1-1.
27. **Hickie I**, Scott E, Burke D, Ricci C, Hadzi-Pavlovic D, Davenport T, Naismith S. (1998) *A depression management program for older patients and their general practitioners*. Sydney: Educational Health Solutions. ISBN No. 0-9587280-4-6.
28. **Hickie I**, Scott E, Ricci C, Hadzi-Pavlovic D, Davenport T, Naismith S. (1998) *A depression management program for patients and their general practitioners (2nd edition)*. Sydney: Educational Health Solutions. ISBN No. 0-9587280-3-8.
29. **Hickie I**. (1998) *SPHERE: A National Depression Project*. Melbourne: Entreg Pty Ltd (video-tape).
30. **Hickie I**. (1998) *Non-pharmacological treatment of depression and anxiety*. Sydney: Educational Health Solutions (audio-tape).
31. **Hickie I**. (1998) *Managing depression and anxiety in general practice*. Sydney: Educational Health Solutions (audio-tape).
32. **Hickie I**, Scott E, Ricci C, Hadzi-Pavlovic D, Davenport T. (1997) *A depression management program for patients and their general practitioners*. Sydney: Educational Health Solutions. ISBN No. 0-9587280-0-3.
33. **Hickie I**. (1996) *Assessing and treating patients with chronic fatigue: integrating medical and psychological approaches*. Sydney: Educational Health Solutions (audio-tape).

Grants Received

National Health & Medical Research Council

Australian Fellowship

1. **Hickie I**. (2008-2012). $4 million over 5 years (Grant ID: 464914).

Research Fellowship

1. **Hickie I.** (2018-2022). *Optimising Personalised Care, at scale, for Young People with Emerging Mood Disorders*. $951,005 over 5 years (APP1136259).
2. **Hickie I.** (2013-2017). *Testing and delivering early interventions for young people with depression*. $883,375 over 5 years (APP ID: 1046899).

Centre for Clinical Research Excellence

1. McGorry P, **Hickie I**, Jackson H, Yung A, Allen N, Edwards J, Chanen A, Lubman D, Berger G, Gleeson J, Berk M, Brewer W. (2005-2009). *Preventive and early intervention strategies in emerging mental disorders in young people*. $2 million over 5 years (Grant ID: 264611).

Centres of Research Excellence

1. **Hickie IB**, McGorry P, Robinson J, Chanen A, Page A, Atkinson JA, Scott E, Judkins S, Buus N. (2020-2025). *Centre for Research Excellence for reducing suicidal thoughts and behaviours in young people presented for health care*. NHMRC. $2,495,765.50 over five years (APP ID: APP1171910).

2. **Hickie IB**, McGorry P, Christensen H, Berk M, Naismith S, Glozier N, Burns J, Guastella A, Davey C, Amminger P. (2013-2018). *Optimising early interventions for young people with emerging mood disorder*. $2,499,420 over five years (APP ID: 1061043).
3. Christensen H, **Hickie IB**, Mackinnon A, Calear A, Batterham P, Martin N Butler J Teesson M, Proudfoot J. (2012-2017). *Improving suicide prevention in Australia through better implementation of effective interventions, improved risk identification and evidence informed policy*. $2,490,060 over five years (APP ID: 1042580).

Partnership Grants

1. McGorry P, Rickwood D, Hetrick S, Pirkis S, Parker A, **Hickie I**, Herrman H, Cooton S, Eagar K. (2014-2018). *Youth-specific change and outcome measures for effective youth mental health service delivery*. $1,475,867 over five years (APP ID: 1076899).

Program Grants

1. McGorry P, Jorm, **Hickie I**, Pantelis C, Yung A. (2009-2013). *Emerging mental disorders in young people: Using clinical staging for prediction, prevention and early intervention*. $10,228,050 over 5 years (Grant ID: 566529).
2. McGorry P, Pantelis C, **Hickie I**, Jackson H, Yung A. (2005-2009). *Emerging severe mental illness in young people: clinical staging, neurobiology, prediction and intervention from vulnerability to recovery*. $7,397,980 over 5 years. (Grant ID: 350241).
3. Parker G, Austin M-PA, **Hickie I**, Hadzi-Pavlovic D, Mitchell P, Wilhelm K. (1995-1999). *Aetiology of Melancholia and related depressive disorders*. $446,000 per year.

Mental Health Targeted Call for Research Grant

1. Amminger A, McGorry P, **Hickie I**, Yung A, Mackinnon A, Berk M, Davey C, Hermens D. (2012-2015). *The Fish Oil Youth Depression Study: A randomised, double blind, placebo-controlled treatment trial*. $1,150,425 over 4 years. (Grant ID: APP1042666).

Project Grants

1. Martin N, Wray N, **Hickie I**, Licinio J, Byrne E, Medland S. *Tackling heterogeneity in the etiology of major depressive disorder* (2015-2019 (Grant ID: 1086683)
2. **Hickie I**, Martin N, Scott J, Gillespie N, Hermens D. *Clinical and neurobiological predictors of onset of major mental disorders (mania, psychosis, severe depression), and associated functional impairment, in adolescent and young adult: A prospective longitudinal study*. $1,291,586 (2014-2018) (Grant ID: APP1069141).
3. Naismith S, **Hickie I**, Christensen H. (2014-2016). *A selective prevention trial using novel pharmacotherapies in an older age cohort at risk for depression*. $947,670 over three years. (Grant ID: APP1060397).
4. Butow P, Tennant C, Tucker K, Meiser B, **Hickie I**, Phillips K, Lo S. (2004-2006). *Psychosocial predictors of developing breast cancer in women from high risk breast cancer families*. $194,244 per year. (Grant ID: 301930).
5. Butow P, **Hickie I**, Tennant C, Tucker K, Berry G, Phillips K. (2001-2003). *Psychosocial predictors of developing breast cancer in women from high risk breast cancer families*. $106,632 per year. (Grant ID: 153824).
6. **Hickie I**, Lloyd A, Davenport T, Wakefield D. (2001-2005). *A prospective study of the psychiatric and medical characteristics of post-infective fatigue and chronic fatigue syndrome*. $100,000 per year. (Grant ID GNT0157052).
7. **Hickie I**, Ward P, Turner K, Naismith S, Scott E, Shnier R. (2000-2002). *Delineating the anatomical correlates of neurocognitive and psychomotor dysfunction in depression by fMRI*. $120,000 per year. (Grant ID: 157052).
8. **Hickie I**, Hadzi-Pavlovic D, Lloyd AR, Wilson A. (1995-1997). *Genetic epidemiology of chronic fatigue and related depressive disorders*. $87,431 per year.

9. Parker G, Hadzi-Pavlovic D, **Hickie I**, Wilhelm K. (1993-1995). *Subclassifying non-melancholic depressive disorders*. $89,000 per year.
10. **Hickie I**, Hadzi-Pavlovic D, Wilson A. (1993-1995). *Is neurasthenia prevalent in primary care?* $70,000 in the first year, then $63,000 for two years.
11. **Hickie I**, Silove D, Wakefield D, Lloyd A. (1991-1993). *A longitudinal study of depression, immunity and physical illness*. $47,000 - $49,000 per year.

Equipment Grants

1. Guastella A, Hawes D, **Hickie I**, Lagopolos J, Glozier N, Menzies R, Naismith S, Matthews S, Einfeld S, Morley K, de Rosnay M. (2013). *Clinical observation and comprehensive psychophysiological recording and behavioural coding equipment.* $50,000.
2. **Hickie I**, Catts S, Wakefield D, Lloyd D. (1996). *Dedicated cryostat for post-mortem brain sectioning*. $33,175.
3. Parker G, Sachdev P, Ward P, **Hickie I**. (1992). *Neuroimaging systems in psychiatry*. $19,000.

Australian Research Council

A. Linkage Grant

1. Guastella A, **Hickie I**, Lagopoulos J, Young L, Banati R, Gregoire MC, Pascali G, Cornett G, Muttenthaler M. (2016 to 2020) *Understanding biological pathways underlying social behaviour in humans*. $1,037,000 over years (Project ID: LP150101307).
2. Calvo R, **Hickie IB**, Doig H, Hosie A, Ratnaike D. (2014-2018). *CyberMate: using digital social media and Internet data to support mental health interventions in young Australians* $357,574 over 4 years (Project ID: LP130100453).
3. **Hickie I**, Burns J, Ellis L. (2008- 2010). *Understanding and preventing mental health difficulties in young Australian males using the Internet*. $357,860 over three years (Project ID: LP0883035).

International

1. Lloyd A, **Hickie I**, Wakefield D, Vollmer-Conna U, Davenport T, Marmion B, Harris R, Khanna, R, Rawlinson B, Geczy A, Dunckley H. (2001-2004). *Post-infective fatigue: a model for chronic fatigue syndrome (CFS).* Centers for Disease Control (USA). US$500,000 per year.

Major National Health Services

1. **Hickie I**. (2007-2009) $1.5 million – included in the $54 million above.
   headspace: National Youth Mental Health Foundation (headspace: McCarthur, Campbelltown and Southern Highlands.
2. **Hickie I.** (2007-2009) $3.9 million – included in the $54 million above.
   headspace: National Youth Mental Health Foundation (National Community Awareness Program) Brain & Mind Research Institute.
3. ORYGEN Youth Health [McGorry P, et al.]; Brain & Mind Research Institute [**Hickie I**, et al.]; Australian Psychological Society; Australian Divisions of General Practice. (2005-2009) *Establishment of the National Youth Mental Health Foundation*. $54 million.

Government Supported

1. **Hickie I**, Iorfino, F. (2020 – 2023). *Explainable machine learning to improve youth mental health care.* Medical Research Future Fund Applied Artificial Intelligence Research in Health, Department of Industry, Innovation and Science. $3.1M.

2. **Hickie I**, Davenport T, Cross S. (2017-2020). *Project Synergy: continuing the co-design, development, implementation and evaluation of the InnoWell Platform*. Australian Government Department of Health. $30M.
3. **Hickie I**, Hermens D. (2012). *Pathways to alcohol induced brain impairment*. NSW Health. Mental Health, Drug and Alcohol Office. $100,150.
4. **Hickie I**. Chair of Scientific Leadership Council. (2011-2016). *Co-operative Research Centre for Young People, Technology and Wellbeing*. Department of Innovation, Industry, Science and Research (Australian Government). $27,647,000 over five years.
5. Christensen H, Griffiths K, Jorm T, **Hickie I**, Moore M. (2003). *Internet-based cognitive behaviour therapy and GP enhanced practice care interventions: a randomised controlled trial*. Australian Government Dept of Health and Ageing. $252,572.
6. **Hickie I**. (2000-2001). *'SPHERE: A National Depression Project'*. Australian Commonwealth Department of Health and Aged Care. $70,000 for two years.
7. **Hickie I**. (2000). *'SPHERE: A National Depression Project'*. New South Wales State Health Department. $50,000.
8. **Hickie I**, Stuhlmiller C. (1997-1998). *Improving the medical care of patients with psychosis*. Commonwealth Transitional Grants Scheme. $50,000.
9. **Hickie I**, Burke D. (1997-1998). *Evaluation of late-life depression in a district mental health service*. Commonwealth Transitional Grants Scheme. $50,000.
10. **Hickie I**, Hadzi-Pavlovic D, Hooker A. (1996). *Identification of somatization in culturally different patient groups*. RADGAC. $25,000.

Industry Supported

1. **Hickie I**, Grunstein R (Woolcock Institute), Carpenter J, Leweke MF, Naismith S, Scott E, Rohleder C, Wilson C, Zmicerevska N, Nichles A, Garland A, Hamilton B, Evans C. (2019-2021). *Effects of adjunctive brexpiprazole on sleep-wake and circadian parameters in youth with depressive syndromes an open-label, mechanistic study*. Lundbeck Australia. $284,884.
2. **Hickie I**, Davenport T, Cross S, Atkinson J, Page A, Scott E, Hamilton B, Nash L, Lee A, Leweke MF, Burke A, (2019-2021). *Best Care, First Time: Can digitally-supported care pathways deliver better care for young people with emerging mood or psychotic disorders?* Bupa Health Foundation. $500,000.
3. **Hickie I**. (2011). *Does circadian disturbance predict response to sleep-wake interventions in early-onset depression?* Servier Laboratories Australia. $100,000.
4. **Hickie I**. (1998-1999). *'SPHERE: A National Depression Project'*. Bristol-Myers Squibb Pharmaceuticals. $40,000.
5. **Hickie I**, Scott E, Hadzi-Pavlovic D, Ricci C. (1997). *Implementation of the SPHERE program in general practice*. Bristol-Myers Squibb. $30,000.
6. Wilson A, **Hickie I**. (1992). *Moclobemide for the treatment of chronic fatigue*. Roche Pharmaceuticals. $10,000.

Other

1. **Hickie IB**. (2019) *Youth mental health education and clinical models of care*. Philanthropy. $1,500,000.
2. **Hickie IB**. (2019) *The design and implementation of clinical care models for the treatment of youth, anxiety, depression and other youth mental health issues*. Philanthropy. $1,414,580.
3. Milton A, **Hickie IB**, Davenport T. (2019-2020). *Crisis resolution team Optimisation and Relapse prevention (CORE) translational research for the Australian and digital environments*. Brain and Mind Centre. $20,000.
4. Naismith SL, **Hickie IB**. (2014-2015). *Transcranial magnetic stimulation for the treatment of sleep disorders in patients 'at-risk' of Alzheimer's Disease*. Mason Foundation National Medical Program. $59,520.
5. Guastella AJ, Young LJ, **Hickie IB**, Thomas E, Andari E. (2012-2014). *Examination of melanocortin receptor agonists in the treatment of autism*. Simons Foundation. $250,000.

6. Guastella AJ, Lagopoulos J, **Hickie IB**, Bennett, M. (2012-2013). *Assessing markers of response to oxytocin as a treatment for autism*. Bupa Health Foundation. $250,000.
7. Glozier N, Christensen H, Griffiths K, Naismith SL, Ritterband, L, **Hickie I**. (2012-13). *An RCT of the efficacy of adjunctive internet based CBTi in treating depression and anxiety in older men*. beyondblue: the national depression and anxiety initiative. $391,364.
8. **Hickie I**. *The Beyond Ageing Project: Phase 2*. (2010-2011). Bupa Health Foundation. $448,634.
9. **Hickie IB**, Naismith SL, Glozier N, Christensen H, Neal B. (2009-2012). *A randomised control trial of a web-based intervention to improve depression, cognitive function and adherence in people with cardiovascular disease*. The National Heart Foundation and beyondblue: the national depression initiative. $594,200.
10. Lloyd A, **Hickie I**, Goldstein, Bennett, Tzarimas, Rogers NL. (2009-2012). *Development of an optimised intervention for post cancer fatigue*. Cancer Council Australia. $435,000.
11. Rogers NL, Whitwell B, **Hickie IB**, Duncan S, Scott E (2009). *Examining sleep-wake behaviours in patients with bipolar disorder*. Pfizer Australia. $81,000.
12. **Hickie I**. (2009). *Patient experiences of care following initiation of zipraisidone - a new atypical antipsychotic treatment*. Pfizer Australia. $250,000.
13. **Hickie I**, Rogers NL. (2009). *Ambulatory polysomnographic assessment system*. Ramaciotti Foundation. $30,000.
14. Pollard JD, Bennett M, **Hickie I**. (2003). *Major Initiative for Biomedical Research in NSW*. Ramaciotti Foundation. $1,000,000.
15. Morgan H, **Hickie I**, Davenport T, Scott E, Sumich H, Blashki G. (2003). *Evaluation of enhanced care training in the treatment of depression by general practitioners*. Effective Healthcare Australia (Seed Grant). $10,000.
16. **Hickie I**, Chenevix-Trench G. (1998-1999). *Psycho-immunity and its relationship to breast cancer*. The Breast Cancer Association of Queensland Incorporated. $25,000 per year.
17. **Hickie I**, Lloyd A. (1999). *Determinants of protracted recovery after Ross River Virus infection*. Australian Rotary Health Research Fund. $30,000.
18. Scott E, **Hickie I**, Ricci C, Lloyd A. (1997). *Identification of Post-malignancy treatment fatigue syndromes*. St George Cancer Care Research Fund. $25,000.
19. **Hickie I**, Good T, Bennett B, Brown R, Dawson D, Lloyd A. (1996). *Establishment of ambulatory assessment of sleep architecture and circadian rhythms in neuropsychiatry*. Clive and Vera Ramaciotti Foundation Research Grant. $14,295.
20. **Hickie I**. (1993-1994). *Harkness Fellowship of the Commonwealth Fund of New York*.
21. Mitchell P, Parker G, Wilhelm K, **Hickie I**. (1991). *The development of the CORE diagnostic system*. Prince Henry Hospital Centenary Grant. $15,000.
22. Scott E, **Hickie I**. (1991). *Autoantibodies in depressive disorders*. Prince Henry Hospital Centenary Grant. $5,000.
23. **Hickie I**, Wilson A. (1991). *Developing a diagnostic instrument for chronic fatigue syndrome (CFS)*. ME Society of New South Wales. $15,000.
24. **Hickie I**, Lloyd A, Wakefield D, Hickie C. (1990). *Immune dysfunction in depression*. Prince Henry Hospital Centenary Grant. $10,000.
25. **Hickie I**. (1988). *Interpersonal relationships and depressive disorders*. Royal Australian and New Zealand College of Psychiatrists. $1,000.
26. **Hickie I**. (1987-1989). *Interpersonal relationships and depressive disorders*. Research Fellowship, New South Wales Institute of Psychiatry. $47,000 per year.