Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF STEVEN MOYLAN

I, Associate Professor Steven Moylan (BSc BMBS(Hons) MPH MPM PhD GAICD FRANZCP *Cert. Old Age Psych*), Clinical Director for Mental Health, Drug and Alcohol Services at Barwon Health, of Barwon Health Corporate Office, Ryrie Street, Geelong, Victoria 3220, say as follows:

1 I am authorised by Barwon Health to make this statement on its behalf.

2 I make this statement based on my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Background and Qualifications

3 I have the following qualifications:

(a) Fellowship of the Royal Australian and New Zealand College of Psychiatrists, with a Certificate of Advanced Training in Psychiatry of Older Age;

(b) Doctor of Philosophy (**PhD**) in Psychiatric Epidemiology from Deakin University;

(c) Graduate member of the Australian Institute of Company Directors;

(d) Master of Psychiatry from the University of Melbourne;

(e) Master of Public Health (**MPH**) from the Harvard T.H. Chan School of Public Health;

(f) Bachelor of Medicine and Bachelor of Surgery with Honours from Flinders University;

(g) Bachelor of Science with Honours from the University of Western Australia.

4 I completed my Psychiatry training with the Royal Australian and New Zealand College of Psychiatry (**RANZCP**) in 2016 with a specialty in Psychiatry of the Old Age.

5 I have worked at Barwon Health since 2008. I started as a Psychiatric Registrar in 2009 before working as a Consultant Psychiatrist. I became the Lead Psychiatrist for Acute, Education and Governance at Barwon Health in 2017 before moving on to my current

role as Clinical Director of Mental Health, Drugs and Alcohol Services (**MHDAS**) in April 2018.

6 As Clinical Director of MHDAS I lead clinical and operational governance of the Mental Health and Drugs and Alcohol program at Barwon Health which includes all acute, community and specialist services provided by Barwon Health in the Barwon region, including a staff of over 400 specialist clinicians and support staff. I am accountable to the Barwon Health Executive.

7 I also serve as a non-executive director at On The Line, a professional social health organisation that provides counselling support for men's mental health, anger management, family violence (using and experiencing), healthy relationships, integrated wellbeing, mental health, chronic health conditions, problematic drug and alcohol abuse and, suicide and trauma.

8 Attached to this statement and marked '**SM-1**' is a copy of my curriculum vitae.

Part A Panel questions

Q1. In thinking about an ideal future community mental health system in Victoria, what are some of the system features, services components or supports that will be critical in effectively supporting:

a. people experiencing mild mental illness?

b. people with moderate mental illness?

c. people experiencing severe or chronic mental illness?

d. families and carers?

9 This is an exceptionally broad question, and I acknowledge my perspective is framed by my predominant experience working with consumers experiencing moderate-severe and chronic mental illness in an area mental health service and their carers.

10 Rather than consider the features, service components or supports of the new system, I suggest focussing on clearly articulating the core principles of care that will *not* change over time.

11 In terms of the principles of care that guide the design of mental health services, it is my belief that our community will always expect services that are:

(a) easy to access when needed (24/7, multichannel);

(b) provided with hope, compassion and the spirit of partnership;

(c) provided by clinicians/workers who can add value to the person seeking care by bringing a range of suitable and appropriate expertise (i.e. multidisciplinary);

(d) so that the person seeking care, and their community, sees benefit from the partnership (i.e. consumers feel better and their capacity improves).

12 Enlivening these principles will require consideration and identification of the core functions each sector of the mental health system must perform to realise the goal of best helping consumers.

13 Put another way, we should not focus on the number, type and location of services but instead define the key guiding principles of the mental health system, and then build the service components that allow us to address these objectives.

14 For an area mental health service (or tertiary provider) like Barwon Health, our expected core functions will continue to include at least the following.

(a) Partnering with people in severe, acute crisis to assist them avoid harm and regain stability. Avoidance of harm may require use of hospitalisation, acute outreach, remote care (i.e. technology enabled care) and in-home care. This would align with a principle that we are there for people when they need it.

(b) Providing multidisciplinary support and care in partnership with consumers with complex needs, to assist achieve their recovery goals. This will include home based, community based, and bed based rehabilitative care delivery. This aligns with a sense of hope that, in partnership, we can assist people to feel better and grow in their function.

15 I would also like to ensure that area mental health services have a strong leadership role in the community mental health sector.

16 The success of the system should be underpinned by a culture of high expectations in which consumers and care givers not only believe that recovery is possible, but recovery is the expected outcome. We are fortunate to already have pockets of champions within the system at the moment driving these beliefs. However, for system wide improvement we need to embed this attitude throughout the whole system.

Q2. At a system level, what strategies can be employed to achieve the right balance between early access to mental health assessment and treatment; and managing the demand for mental health services?

17 I believe it is integral to get the front door right. It should not be difficult for consumers, carers and others to understand how to get help if and when it is needed. If somebody

needs a mental health assessment they should be able to be assessed, receive appropriate advice and be supported to take the next step. It is too difficult at present for people to understand where to best get support.

18 It is therefore vital we work to simplify the process for consumers and carers to seek assistance. There are simply far too many entry points. It is my view that entrance to the system for clinical care should be supported through our primary care system.

19 With appropriate system entrance and guidance around navigation, I believe we will learn that a choice between early intervention and demand management is a false dichotomy, as effective early intervention and partnership with primary care has significant positive influences on demand. I believe there is significant avoidable demand in the system which relates to the system issues, both a lack of clarity for consumers for how the system integrates and functions, and a lack of role clarity for individual providers.

Q3. Commissioning strategies from Victorian and Australian Governments have progressively sought consortia models to procure the scope of services required in complex human service programs. Given your collective experience across a range of sectors (Health Services, Community Health, Primary Health Networks (PHN), private hospitals), can you please outline the strengths and weaknesses of consortia as a commissioning approach?

20 Barwon Health is the lead agency of the Alcohol and Other Drugs (**AOD**) Consortium with Stepping Up, the Salvation Army and Colac Area Health. The Barwon AOD Consortium delivers intake, assessment, care and recovery coordination, counselling and non-residential withdrawal services.

21 While the Barwon AOD Consortium links Barwon Health to a range of other health services, it is not an ideal structure due to complicated bureaucracies, mixed communication channels and the differing demands of each agency. For example, in circumstances where Barwon Health controls the intake but the consortia agencies provide the treatment, the pathway disconnects when the intake service directs patients to agencies with no capacity to provide care. Significant resources are required to effectively manage consortia models.

22 The Department of Health and Human Services (**DHHS**) Early Intervention Psychosocial Support and Response (**EIPSR**) program is an example of service commissioning facilitated by area mental health services. Psychosocial services are a vital component of mental health care but are not typically provided by area mental health services. The rationale for funding the EIPSR program through area mental health services was to develop strong relationships with community mental health

providers. However, some lessons have been learnt from this program. First, the resources and expertise required to commission services are significant, particularly as many services lack commissioning experience. Secondly, while rolling out a service within the expertise of an area mental health service is straightforward, the implementation of complex contracting and managing multiple stakeholders is time consuming and at the limits of an area mental health service's capacity. Therefore, whilst commissioning has many benefits, the true cost of undertaking the commissioning must be considered and appropriately resourced.

23 The commissioning of EIPSR also highlighted another key issue in mental health service provision – inadequate coordination between commissioning agencies. While Barwon Health were commissioning our psychosocial support program, our local PHN were commissioning an almost identical program commissioned by the Commonwealth Government of which we were unaware. The opportunity to undertake a combined commissioning, which could have achieved greater value, reduced duplication, and provided a more coherent service system, was missed.

24 Overall, I feel that commissioning has significant potential value, but it needs to be done with sufficient scale and coordination to ensure services are not duplicative and/or gaps in service provision don't arise.

Q4. What do you think are the most significant issues facing community mental health workforces?

25 The most significant issues for community mental health workforces include:

(a) a culture of institutional care and loss of hope for our consumer groups (not universal, but present);

(b) a generational gap in the workforce;

(c) a lack of diversity of workforce, particularly in discipline background;

(d) poorly articulated career pathways with challenging industrial agreements; and

(e) difficulty attracting staff to public work (especially the medical workforce currently engaged in the private system).

26 Models of community mental health care in area mental health services have many elements of a "community institutionalisation" model – essentially a transfer of traditional bed based institutional models of care into community settings. This model of care has many elements of the care models seen in nursing practice. This has many advantages: nursing care models are excellent at delivering compassionate care, creating

relationships with people over time and providing a clear delineation between the medical and nurse roles. However, a potential disadvantage is that nursing models of care are premised on providing continuous care for longer periods (e.g. in aged care services) and maintaining stability which is a different model to one seen in rehabilitation models of care, where multidisciplinary inputs are provided to assist a person achieve functional gains and recovery.

27 The predominance of the nursing model of care has influenced the current deficits in the numbers and availability of allied health and associated workforces in area mental health service provision. Traditional models have driven all generic clinician roles, based largely on nursing type functions. A major challenge in achieving new outcomes will be enhancing the input of discipline specific roles in area mental health services, aligning the right discipline and therapeutic inputs for each individual consumer's needs.

28 Achieving this will need attention to appropriate discipline specific training and career pathways, and a wider effort in system leadership to signal a change to incorporating the essential requirement of allied health inputs into care provision. As an observation, currently DHHS has an Office of Chief Psychiatrist and Office of Chief Mental Health Nurse. These signal the pre-eminent role of medical and nursing disciplines in mental health service delivery. It will be important to address such institutional signals to support cultural change.

29 There also exists a generational gap in the current mental health workforce. An older generation, often trained in the institutional era, combined with a younger workforce who have progressed through more newly established training pathways. There appears to be less density of a middle career workforce.

30 There are challenges in establishing enriching career development pathways across all disciplines in mental health services. This is influenced by restrictive industrial agreements, which can restrict career progression, opportunities to broaden experiences, and career pathways in certain areas. For example, current industrial agreements negatively incentivise development of inpatient nursing careers, as opportunities for grade advancements (i.e. Nursing Grade 2 to 3) are far more prevalent in community based settings. Transformative change in the mental health sector requires a refresh of the industrial agreements to support flexibility in nursing, allied health and associated career advancement options in order to achieve the desired community outcomes from the system.

Q5. The Commission's interim report anticipates that '[a] contemporary workforce will be required to work in a diverse range of settings, with a greater emphasis on online services'. What is needed to help build and develop a workforce that meets these requirements?

31 Developing a fit for purpose contemporary workforce will require mapping the required functions of the system and then developing roles to meet these functions. Currently we are preoccupied with "who will provide the care" (i.e. the number of doctors, nurses, psychologists, etc.) rather than with "what care is required, and why" – the essential functions of the system.

32 Above and beyond mapping the functions, and developing pathways to train this workforce, is the need for cultural change. We need to foster people's excitement to work in mental health – whilst in high school, during university study and in the workforce. We can do that by positioning mental health as a positive and aspirational industry.

33 A key opportunity to help build and develop the workforce is to promote telehealth. Telehealth is advantageous in facilitating consumers to access services at their own convenience without having to attend a mental health service in person. We would need to adapt our workforce to provide telehealth services and there are opportunities to capitalise on latent capacity in the system. For example, mental health workers would be able to access more flexible working arrangements by working out of hours or on the weekend (although industrial agreement changes may be needed to support this). Telehealth also has the ability to access workers or specialities in different geographic areas and even create international partnerships. Once again, leadership and adequate resourcing is crucial to ensure the effective implementation of telehealth.

34 A simple example that may highlight this opportunity is the possibility for area mental health services to partner with community mental health organisations via telehealth platforms. In our region, we are exploring a partnership with Bellarine Community Health where consumers could utilise their infrastructure to access a safe space, close to home, with reliable infrastructure, to receive specialist services via telehealth.

Q6. The service model used in Trieste in Italy appears to adopt a unique approach to the delivery of mental health services and a unique service configuration.

- ***a. to what extent do you think this model could be successfully implemented in Victoria?***
- ***b. do you consider there are any cultural, contextual or setting differences between Trieste and Victoria that could limit the application of the Trieste model in Victoria?***
- ***c. what are other examples of unique community mental health models in other jurisdictions that are having a positive impact on consumer outcomes?***
  - ***i. What are their key features?***

35 My understanding is that the Trieste model in Italy is a series of strong, and small, community based services with a 24-hour community health system hub with a small attached inpatient unit. The model also operates on rehabilitation targets which focus on broad social issues.

36 Whilst held in appropriate high esteem, it is important to note that density of inpatient beds in Trieste are not dissimilar to the current state at Barwon Health. I would also note that since the implementation of the Trieste model in the 1980s and 1990s the dynamics and expectations of mental health services has evolved – particularly in relation to providing emergency care related to drug and alcohol intoxication.

37 The advantages of the Trieste model appear to stem from the small community centres that provide care, available to consumers when they need it, with strong partnerships with the local community enhanced by the ability to provide care closer to a patient's home. It also emphasises the predominant role of community based care, with inpatient care reserved for situations where other care options are not viable (e.g. akin to intensive care treatment). Barwon Health's strategic reforms align with this model, particularly our decision to move operations into new community youth, adult and drug and alcohol treatment hubs (four across our region), which would serve the same functions that are undertaken in Trieste including extended hours care.

Part B Individual questions

Community-based mental health services and crisis response

Community based mental health services provided by Barwon Health

38 Barwon Health provides services to Victorians from a large and diverse geography which approximates the City of Greater Geelong, Borough of Queenscliffe, Surf Coast Shire and Colac Otway Shire. The total population covered is approximately 315,000 people which is growing at approximately twice the rate of the rest of the State.

39 Barwon Health provides community based mental health services to all ages:

(a) community acute intervention services (all ages);

(b) child and adolescent mental health services (0-15 years);

(c) Jigsaw youth services (16-25 years);

(d) adult community mental health services (26-64 years);

(e) aged psychiatry services (65+ years);

(f) eating disorders services;

(g) complex care and forensic specialist services;

(h) primary mental health services; and

(i) drug and alcohol services.

40 A core function of our service provision is to assist consumers, irrespective of diagnosis, who are in acute crisis to prevent harm and regain stability. We call this providing our community a “safety net”. Doing this successfully requires a strong relationship with our community, transparent access, partnerships with community providers, smooth pathways and a posture towards being active and flexible in providing assistance.

PACER and PROMPT

41 PACER (Mental Health and Police) and the current PROMPT AV trial (Mental Health and Ambulance) allow consumers to connect with mental health services in the community as a proactive emergency mental health response.

42 The emergency department should be the last place people access mental health care because the environment exposes them to a heightened risk of agitation, disruption, restrictive practice and inpatient admission. If the system can provide a more appropriate front door to access mental health care, the negative impact on consumers will be minimised.

43 The PACER and PROMPT services embed mental health clinicians to work with emergency responders (police, ambulance), such that initial triaging and assessment can occur at the point of care in the community rather than requiring transfer to an emergency department.

44 Although PACER and PROMPT do have high, quantifiable up-front costs, these are balanced by savings elsewhere. Often there is a tangible financial cost of assessing and

managing people's care in an emergency department prior to transfer to an inpatient unit, in addition to the intangible social costs to the individual and their carers.

45 These infield service responses could be further improved through the use of telehealth capability in partnership with emergency services, similar to the secondary consultation services available to the care of consumers who potentially experience a cerebrovascular event (stroke).

Role of emergency departments in the ideal mental health service response

46 Emergency departments will continue to play a key role in providing mental health care. While it is important that wherever possible people are able to receive care elsewhere (i.e. know how to access care in the community), when in the emergency department consumers must have fast access to assessment and appropriate expertise and care in a welcoming and supportive environment. The key elements include comfortable waiting areas and consulting suites in a calm area of the department. The design of the Mental Health and Alcohol and Other Drug Hubs in the emergency department at Barwon Health incorporates such areas which I feel will greatly benefit our consumers.

47 After appropriate assessment, it is vital that community based services have sufficient capacity to ensure the consumer care journey can be transferred to the community in a safe, integrated fashion. This would include close connections with community hubs and in-reach services into consumer homes.

48 One important element of the emergency department care will be the role of lived experience workers. People with prior experience in the system provide more than advice about how to navigate the system. Peer workers connect with mental health patients by listening to and understanding the challenges those patients experience and supporting consumers to feel comfortable with the process. At the same time, lived experience workers help clinicians understand how it feels like to be in the system which drives engagement, effectiveness and empathy.

Hospital in the Home

49 Barwon Health is in the process of developing a Hospital in the Home model of care which will provide acute, hospital level treatment, for consumers in the community setting as an alternative to inpatient care. This program has been funded from new acute adult and youth beds we have been allocated in response to the interim recommendations of this Royal Commission.

50 If we are going to make programs such as this successful, we must view them as true models of bed substitution, and ensure that resourcing of them in terms of staffing and

multidisciplinary input is the equivalent of, or even enhanced above, that provided for traditional inpatient care.

51 Providing individualised care for consumers in a community setting, as opposed to an inpatient environment, has the potential to have significant consumer and societal benefits.

52 Providing this care effectively may require additional costs as compared to traditional bed based care (as there is some loss of economies of scale provided by grouping consumers together in an inpatient environment). However, it is likely these costs will be recouped later, through the avoidance of the true personal, cultural, societal and economic costs associated with providing care in inpatient units.

53 If our ambition is to provide individualised care to consumers, with a view to partnering in their recovery, supporting programs like hospital in the home is in my view a great step to achieving this.

Physical Healthcare for consumers receiving community care

54 It is well documented that mental health consumers have poorer physical health outcomes than non-mental health consumers. This is contributed to by multiple factors (lifestyle risk factors, socioeconomic disadvantage, illness and treatment characteristics), one of which is poorer access to primary health prevention, screening and monitoring.

55 Despite multiple programs that have been aimed at improving outcomes in this regard, the outcomes continue to remain poor. A re-imagination is required.

56 In my view, there are clear opportunities for area mental health services to partner with community health providers (i.e. community nursing, those running population health interventions, and general practice) to share resources and expertise to provide a whole of health service for the consumer.

57 As a localised example, we have commenced exploring a partnership with both the Barwon Health integrated community health services, and Bellarine Community Health (a local independent community health provider) to provide shared service provision to consumers receiving acute and rehabilitative mental health care.

Geographic Catchments

Advantages and disadvantages of catchments

58 From an area mental health service perspective, it is worth considering why geographic catchments exist for mental health but not for other aspects of acute healthcare. One

could argue that the catchments provide greater advantages to a system that is area (i.e. block) funded as opposed to activity funded, and are drawn from a historical perspective of institutional care.

59 In saying this, geographic catchments provide clear boundaries which can assist in service planning. Catchments can also be a mechanism for incentivising coordination between different services where boundaries are shared.

60 On the other hand, geographic catchments can contribute to consumer confusion as to what services are available and how to access them. Catchments also limit the choice available to patients to access the care they need. For example, it is irrational for consumers living on different sides of a single street to be unable to access the same services.

61 In my view, where geographic divisions are made, the area should be large enough to ensure consumers can receive the majority of services they require within that catchment. However, consumers should be able to access services when and where they need them, based on individual preferences.

62 There is no clear optimal catchment size or range. At the moment, Barwon Health's catchment spans the G21 region of five local government areas with a population of approximately 350,000. This region has sufficient scale for Barwon Health to provide a comprehensive array of core services, including afterhours service responses, although a population basis of approximately 500,000 would provide the capacity to provide more specialised low-volume services. The relative medium-low density of the population and the geographic size of the catchment compounds the issue as providing services over a longer distance brings different challenges than in population dense areas. Constraining the geographic size of a catchment is also important for maintaining strong partnerships with community organisations and primary care providers – as catchments increase the nature of these partnerships can be harder to maintain. The catchments must be designed around the particular characteristics of the geographic areas to service the natural flow of people. For example, I feel that coordination of care across the Barwon and Glenelg area mental health service catchments would have significant advantages, as it would align acute service provision with the Western Victoria PHN, and would follow natural flows of consumers seeking specialist care into the regional hub, Geelong.

63 As a general principle, I feel it is vital that if geographic areas are pursued, the catchments should align with local government areas (**LGAs**) because these populations are well defined, and data sources available for planning most commonly use these boundaries. Non-alignment with LGAs complicates planning efforts.

64 I also believe it is important that there are consistent catchments across age groups. Inconsistent catchments for age based cohorts cause confusion for consumers and care providers.

65 Small catchment areas (in terms of population) can experience challenges due to their smaller service capacities.

Alternatives to catchments

66 While acknowledging the necessity for some geographic delineation, a core principle should be that the care of consumers in all situations (excepting highly specialised services) can be provided within the region. The model needs to be flipped from prescribing services based on what is available within a region, to facilitating access to the required care for people utilising local and specialist networks across the state, whenever and wherever they need it.

Risks of abolishing catchments for community-based care

67 The risk of abolishing catchments for community based care is that we do not have the capacity to provide comprehensive local services to meet community need across the whole of the state.

68 In addition, some aspects of care do benefit from localisation within a region. For example, without geographic boundaries there may be a tendency to collapse the distribution of services into a smaller number of higher scale services. This would reduce local access for consumers which would be significantly more problematic for chronic condition care (e.g. rehabilitative services). Further, it may increase confusion about how and where to access services.

69 Abolishing catchments would require significant funding interventions to maintain local access to services for areas of relatively low population density across the state

Streaming

70 The mental health system should incorporate streaming, but care should be streamed through the holistic provision of health care, rather than as a separate subset of mental health care. At the moment, the streams of mental health care are failing to take advantage of natural synergies which exist in the broader health care framework because the streams are confined within mental health.

71 For example, children's health care should include mental health care and any specialist children's mental health service should be co-located and ideally work in an integrated model of care with paediatrics to provide a whole of health comprehensive package of

care. Parents should not be required to take children to different places to receive health care and mental health care, it should be located in one place. This is the model Barwon Health will pursue as part of its Women's and Children's Hospital development.

72 Similar models of age based streaming can occur for older person's mental health services, aligned with appropriate older person's health services (e.g. geriatric medicine).

73 From a system design perspective there are many potential streams or care segments that can be produced. Ideally the system would accommodate individualised care based on an individual's needs, delivered as a package of care within an appropriate health service stream.

State-wide services

74 In its submission to the Royal Commission, Barwon Health recommended the development of a "state-wide service plan" that outlines the mental health, alcohol and other drug services that should be available to all Victorians via area mental health services. The submission suggested that service availability should be informed by current and projected population size, complexity and the factors related to the social determinants of mental health. Further, the submission recommended that the plan outlines which services should be available at a local level and which should be available via state-wide specialist referral pathways.

75 The key criteria for determining which services are offered on a centralised state-wide basis, compared to a local basis should be the relative specialisation of the service, the demand level, and how the service interacts with other key systems.

Coordination and stepped care across community, primary and specialist care

76 The key system-level barriers to coordination and stepped care include:

(a) funding – primary and specialist care are funded differently which drives divergent practitioner behaviour;

(b) insufficient data – primary and specialist care do not have access to shared data so we cannot assess the current demand for services, whether the demand is being met and which services are providing the care. The consequence is that there is discoordination between the services;

(c) inadequate delineation of scope – it is not clearly articulated who is responsible for what; and

(d) insufficient system wide leadership – no aligned service leadership to achieve the relevant objective.

77 Coordination, communication and clear system leadership is paramount to providing effective care across PHNs, AOD, specialist care and other services. The system requires structures that prescribe the role of each service, coupled with single system leadership.

78 Rather than being prescriptive as to the precise services that are to be provided and how, what is needed is clear articulation of the role and scope of services to be provided within each region and then it is important that each local service system has the opportunity to explore the most appropriate arrangements for their local area based upon local factors. Support to develop appropriate system leadership is key to this, as it is through this leadership that partnerships and other shared arrangements are facilitated.

79 Co-location can work but it requires coordination. Where there is no communication between the different service providers, co-location brings little benefit. Opportunities for co-location can be productive, but it is only a part of the solution.

Difficulties accessing primary care in the Geelong region

80 People with serious mental health disorders have difficulties accessing GPs in the Geelong region for the following reasons.

(a) The number of GPs in the Geelong region is lower than other parts of Victoria in proportion to the population.

(b) The inequitable access to GPs will continue to escalate as the Geelong region experiences higher population growth than other areas in Victoria.

(c) People with severe mental health issues are disproportionately poor which means that those who can access the service may not be able to afford it.

(d) GPs are not appropriately financially incentivised to provide high quality mental health care which often requires longer consultation periods.

(e) Lastly, like in all areas of practice, GPs require fast turnaround specialist support to assist their practice. This has been challenging to achieve in mental health due to relatively low specialist numbers, high demands upon specialists and lack of incentives to provide rapid outpatient psychiatric services (including funding and policy streams).

Psychosocial supports

81 In its submission to the Royal Commission, Barwon Health recommended appropriate investment into effective psychosocial support services and other initiatives that systemically address the social determinants of mental health. The submission recommended that additional investment in psychosocial services should include, but should not limited to, investment in crisis and social housing, and efforts to improve physical health for mental health consumers.

82 Psychosocial intervention should be an integral part of the healthcare system. Area mental health services should be able to provide psychosocial support or, at the very least, have effective linkages to other organisations that can provide those services. Many of our consumers do not have the independent capacity to access health services (or housing, carer support or Centrelink).

83 I support the current arrangements in which area mental health services can commission psychosocial supports, as an interim measure to support consumers that rely on the National Disability Insurance Scheme, and believe such a program should be expanded.

Impact of unstable housing on the provision of mental health services

84 In its submission to the Royal Commission, Barwon Health noted that the social determinants of mental health, which are closely linked to social inequality (and include factors such as early childhood neglect and trauma, poverty, social disenfranchisement, homelessness, disability and family violence), have a substantial effect on consumers.

85 A major social determinant that perpetuates mental illness morbidity for consumers in the Barwon region is homelessness. In fact, in the middle of June 2019, 60% of consumers admitted to Barwon Health's acute psychiatric unit and sub-acute units were homeless or had unstable housing.

86 Unstable housing is a contributing factor to mental health. Supporting consumers to transition from unstable housing to stable housing will contribute to better mental health.

87 Once consumers have been treated, a lack of stable housing also delays discharge from hospital. Access to appropriate housing support, including crisis housing, would facilitate patients to be discharged more efficiently and free up capacity inpatient beds for others.

88 The key support these clients require is more accessible housing and services to link them to that housing. In addition, there needs to be a concerted focus in ensuring the

programs are delivered with the same degree of urgency and importance as clinical interventions.

89 Mental health services need appropriate linkages to homeless support services to improve outcomes. However, it is not enough to allocate a housing support worker to each area mental health service and expect that person to solve the problem. If there are no services to link consumers to or no housing options available then this will be of little to no effect.

90 For example, Mind Australia and the Haven Foundation have created a program that provides a stable and supported living environment for people who are at risk of homelessness and inadequate management of mental health conditions. The program gives people the opportunity to receive improved care and support, and models such as this could prove valuable going forward as sustainable mechanisms to provide supported accommodation.

Forensic mental health

91 Occasionally, people incarcerated at Ravenhall Correctional Centre have been released directly to the emergency department at Barwon Health for mental health treatment. A direct release from a correctional centre to an area mental health service reflects the limited capacity of the justice system to handle the demand for mental health services in our prison system.

92 More appropriate linkages, including enhanced Forensic Mental Health Services and resourced handover processes (option for telehealth), may improve this care provision.

Governance of area mental health services

93 There is an opportunity to improve the regulatory oversight mechanisms for mental health care. The current system has multiple bodies, and there is a lack of clarity around roles and functions amongst those bodies. Currently, Barwon Health reports or engages with multiple bodies that regulate care, including:

(a) DHHS and its associated branches;

(b) the Office of the Chief Psychiatrist;

(c) the Mental Health Tribunal;

(d) the Mental Health Complaints Commission;

(e) Community Visitors;

(f) the Office of the Chief Mental Health Nurse;

(g) Safer Care Victoria; and

(h) the Australian Commission on Safety and Quality in Healthcare.

94 These regulatory bodies can have multiple overlapping functions which can lead to duplication of work required within the area mental health service. As an example, a single complaint from a consumer can lead to requests for required responses from the Office of the Chief Psychiatrist and the Mental Health Complaints Commission and requests for information from Community Visitors.

95 Governance arrangements need to be simplified. Many of the new regulatory bodies have been created to address gaps or deficiencies in existing regulatory bodies rather than fixing the underlying issues.

96 In my view, there is a unique need for a Chief Psychiatrist to regulate and enforce the provisions of the *Mental Health Act 2014* (Vic). However, it may be more appropriate to collapse the quality and safety functions currently spread across other bodies into a single body (e.g. DHHS or Safer Care Victoria).

97 Governance of mental health care should not be separated from governance of other acute health services. It would be stigmatising to do so. The integration of mental health services into overall health care forces boards and CEOs to be accountable and reinforces the reality that mental health services are a vital part of overall health service delivery. For this reason I believe it is necessary that governance of mental health services remains within health services more broadly.

Incentivising innovation

98 The system needs to find a balance between specifying the nature and scope of services should be provided and leaving the health service to then determine the manner in which the local mental health services can provide this care. Area mental health services must have the flexibility to provide programs in the best way to suit the local community. It is important to trust and support local leadership, and avoid being overly prescriptive at a system level. To achieve this, commissioning agencies should refrain from specifying inputs (e.g. how many EFT), and rather define outcomes to be achieved, establish principles and guidelines, and institute modern performance management approaches informed by good information.

99 Barwon Health has partnered with Deakin University to develop the Change to Improve Mental Health Centre for Excellence (**CHIME**). CHIME aims to combine both institutions' innovation, research and evaluation expertise, service redesign and the pursuit of

clinical excellence to establish a 'living lab' that embeds expertise and generates new knowledge. Initial projects may include evaluation of the Barwon Health's telehealth response to COVID-19, development and implementation of our Hospital in the Home initiative, and development of our new community youth and adult hub model.

COVID-19

100 The COVID-19 pandemic compelled area mental health services to change the way mental health services are delivered to consumers. Broadly, there have been two key changes to the manner in which mental health services have been provided during this period:

(a) an increase in the utilisation of telehealth; and

(b) an increase in the threshold to provide mental health care in inpatient units which has been balanced by an increase in care delivered in the community.

101 The first change driven by COVID-19 is that area mental health services have become, by necessity, reliant on telehealth as a means of providing care. The uptake of telehealth services has been patchy, with child and youth, psychology and allied health services embracing the change, while adult services uptake has been more limited.

102 In respect of the telehealth services that Barwon Health have able to provide, we noticed a digital divide between consumers who have the necessary technology (i.e. hardware, internet connection and data allowance) and those consumers who do not. The divide is further exaggerated by the fact that the lockdown measures prevent consumers from accessing community based services (i.e. public libraries, internet cafes etc.) which would be available in normal circumstances.

103 Barwon Health has also noticed a suppression in demand for mental health services in the initial weeks following the declaration of a state of emergency. While the fall in demand for these services may be attributed to an inability to access or an unwillingness to use telehealth services, it is also likely to be caused by positive drivers. First, family unit support has increased as a result of social distancing, isolation and the collective experience of the managing the crisis. Secondly, the disruption of COVID-19 has resulted in some consumers being released from the 'care cycle'. The mental health system, born from an institutionalised basis, can breed a symbiotic relationship between patient and carer whereby each become reliant on the other. The pandemic has released some consumers from a sense of obligation to attend or an over reliance on mental health services which may, in some circumstances, be beneficial.

104 The second key change driven by COVID-19 is that area mental health services have been forced to increase the threshold of illness required to be admitted to the inpatient

care unit and, in response, care has been provided in consumers' homes through a greater investment in community outreach services, available 7 days a week over extended hours. Interestingly, keeping the occupancy rate in the inpatient unit at 75%-80%, with a view to enhancing social distancing, has not resulted in any negative outcomes for consumers that we have observed to date. Our experience so far during this pandemic is that we can maintain a higher threshold to admit people into the inpatient unit and safely provide care in the community.

105 Since the COVID-19 pandemic began, Barwon Health has been actively applying resources to support people in the home. We changed our model to become function based by collapsing community based teams together which has allowed a multidisciplinary group to provide care extended hours 7 days a week so that people can be seen by a specialist psychiatrist or psychiatric registrar in their home. The mental health system must embrace these kinds of proactive community based services, supported by a cultural acknowledgement that providing care proactively, in the community, is the preferred outcome wherever possible. Area mental health services should aspire to create a welcoming environment for people in crisis while also recognising that inpatient care should be the last resort.

106 We should note that we have been unable to implement such an effective community based care model in the past because of structural issues and resourcing restraints. The public health risk of COVID-19, however, created an "all bets are off" environment in which we had the freedom to implement this model of care. It is critical to acknowledge that unless community centred care is culturally reinforced in the system, it is likely that the system will revert back after the pandemic.

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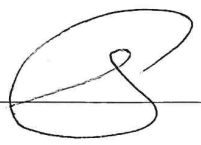

print name Steven Moylan

date 29 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT SM-1

This is the attachment marked '**SM-1**' referred to in the witness statement of Steve Moylan dated 29 May 2020.

Associate Professor Steven Moylan

BSc BMBS(Hons) MPH *(Harvard)* MPM PhD GAICD FRANZCP *Cert. Old Age Psych.*

EDUCATION & PROFESSIONAL QUALIFICATIONS

2017 –: Master of Business Administration, Business School, Deakin University

- In progress

2009 – 2016: Fellowship, Royal Australian and New Zealand College of Psychiatrists

- Awarded Fellowship as a Consultant Psychiatrist in both General Psychiatry and Advanced Certificate in Psychiatry of the Old Age (Geriatric Psychiatry)
- Awarded the Maddison Medallion (2017) for Most Meritorious Performance among all speciality doctor trainees during Fellowship training across Australia and New Zealand
- Awarded the Early Career Psychiatrist of the Year (2015) for authoring the most important scientific publication by an early career psychiatrist or trainee in the calendar year

2015: Company Directors Course, Australian Institute of Company Directors

2010 – 2015: Doctor of Philosophy, School of Medicine, Deakin University

- PhD: utilising epidemiological techniques to analyse population data in Australia and Norway, demonstrated that exposure to cigarette smoke in early life may increase expression of anxiety symptoms and disorders in late adolescence and adulthood. The results of this investigation are being used to inform mental health prevention and early intervention efforts.

2009 – 2015: Master of Psychiatry, School of Medicine, University of Melbourne

2009 – 2010: Master of Public Health, School of Public Health, Harvard University

- Awarded a Frank Knox Memorial Fellowship to undertake specialist public health training, and leadership and management training at the Harvard Kennedy School of Government and the Harvard Business School
- Graduated with a GPA of 3.94 (of 4)
- Class Valedictorian

2004 – 2007: Bachelor of Medicine & Bachelor of Surgery (Hons), Flinders University

- Awarded the University Medal
- Awarded the Medical Association Medal for most outstanding contribution to student affairs

2000 – 2003: Bachelor of Science, University of Western Australia

- Awarded the Ralf Schimmel Prize (2003) for the highest performance in Physiology

EMPLOYMENT HISTORY

Feb 2017 – Current: Lead Psychiatrist: Acute, Education & Governance, Mental Health Drugs & Alcohol Services, Barwon Health

- Barwon Health is the area public health care provider for the Barwon Region (pop 350,000), and the largest health service in South Western Victoria.

- In this role, I lead and have accountability for clinical governance of our acute services, including our acute inpatient unit and emergency department care. This involves leading a workforce of over 100, including Consultant Psychiatrists, psychiatry trainees, general medical officers, and specialist nursing and allied health staff to provide high quality mental health care to individuals and families, often in times of crisis. The role requires significant liaison with other health service departments and mental health providers in Victoria, in addition to governmental bodies.
- In addition, I lead and coordinate the training of our next generation of Consultant Psychiatrists (26 trainees at present), and coordinate the Deakin University Medical School mental health rotation curriculum.

Feb 2016 – Current: Consultant Psychiatrist in Public and Private Practice

- Provide clinical psychiatric services in public and private settings. At present, this includes private bulk-billing services, specialist in-reach into a secure psychogeriatric aged care facility, and specialty practice in the Barwon Health Memory Disorders clinic. I have previously coordinated the clinical care of the Corio Community Mental Health team – the most disadvantaged and highest acuity population in the Barwon Mental Health catchment.

Aug 2017 – Current: Clinical Associate Professor, Deakin University

- Convenor of Mental Health Curriculum, Deakin Medical School

Jan 2010 – Jul 17: Clinical Lecturer, School of Medicine, Deakin University

- Provide education to training doctors, nurses and allied health students undertaking mental health training.
- Awarded the Inaugural Best Registrar for Clinical Education (2009/10)

Feb 2012 – Nov 2014: Program Manager, Australian American Young Leadership Dialogue (AAYLD)

- The AAYLD is a bilateral, bipartisan initiative which aims to connect young leaders aged 25-37 from diverse fields to promote mutual understanding and foster relationships which will strengthen the Australia-American alliance.
- In my role as program manager I was responsible for:
  - Selecting candidates (by application and interview);
  - Developing program events, including twice yearly conferences; and
  - Ensuring active participation and inclusion of delegates through promoting a respectful and positive environment.

Feb 2012 – Feb 2013: Associate Podcast Editor, Royal College of Psychiatrists UK

Oct 2011 – Jul 2012: Academic Fellow, Imperial College London

Feb 2009 – Jan 2016: Psychiatry Registrar, Barwon Health

- Chief Resident, Mental Health Drugs and Alcohol Services, 2013-2016

BOARDS & REPRESENTATIVE ACTIVITIES

2017 – Current: Non-Executive Director, On The Line

- On The Line is a leading social health business providing telephone and web based counselling services to people throughout Australia through various lines including MensLine Australia and Suicide Call Back Service.

2016 – Current: Advisory Council, Mental Health Complaints Commission

- The council provides advice to the Commission across multiple areas of mental health care activity including processes relating to management of complaints arising from mental health care.

2015 – Current: Non-Executive Director, Global Voices

- Global Voices creates opportunities for young people to be heard in international forums such as the G20, APEC, IMF and Climate Change negotiations (e.g. COP).

2014 – 2015: Trainee Advisory Board, Australian and New Zealand Journal of Psychiatry

2013 – 2015: Chief Resident, Mental Health & Drug & Alcohol Services, Barwon Health Chief Residents

- The Barwon Health Chief Residents provide strategic leadership to matters influencing the training and work function of junior doctors at Barwon Health

2009 – 2010: President, Australian Medical Association (VIC) Doctors in Training Subdivision

- The AMA (Vic) DIT Subdivision is the peak representative for junior medical officers practicing in Victoria, Australia.

COMMUNITY ROLES AND AWARDS

2015 – Current: Vice Captain, Geelong Gaels Irish Football Club

- Best and Fairest, 2015

2009 – 2010: Coordinator and Founder, Community Health Literacy Project, Education Development Group, Boston MA

- Project empowered people from culturally and linguistically diverse backgrounds to engage in health care through improving health literacy.

2009: Founding Organiser, Teddy Bear Hospital Project, Victoria

- Organised the first "Teddy Bear Hospital" in Victoria, which has subsequently been incorporated into the diverse range of fundraising activities coordinated by the Royal Children's Hospital as part of the Good Friday Appeal.

2003: Commendation for Brave Conduct, Bali bombings, Bali Indonesia

- Awarded by Governor of Western Australia Lt-Gen John Sanderson, "For acts of bravery considered worthy of recognition**"**

RESEARCH PUBLICATIONS

List available on request