ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Held via Zoom

On Tuesday, 16 June 2020 at 10am

Before: Ms Penny Armytage AM (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Mr Stephen O'Meara QC
Ms Georgina Coghlan
Ms Fiona Batten

THE CHAIR: Good morning, everyone, we might get started. Welcome to the Commission's panel discussion on service configuration. I'm Penny Armytage, the Chair of the Royal Commission into Victoria's Mental Health System. I am joined by my fellow Commissioners, Professor Allan Fels, Dr Alex Cockram and Professor Bernadette McSherry.

On behalf of the Commission I acknowledge Aboriginal peoples as the traditional owners across all the lands on which we are based for today's panel discussion, and I pay my respects to their Elders past, present and emerging.

Before we commence, I would like to acknowledge the breadth of the issues we are covering today and to thank Dr Margaret Grigg, Julie Anderson and Peter Kelly for taking the time to participate in today's panel. I know a considerable amount of effort has gone into the development of your witness statements and into the preparation for today's discussions.

We are particularly mindful of the time that you have afforded us in the context of the current pandemic. We appreciate that you are likely managing competing priorities, and your generosity and flexibility in this environment will go a long way to supporting the Commission in what is becoming increasingly important work.

Today's panel discussion is intended to provide an opportunity to actively engage and interact with issues around the configuration of the mental health service system. In particular, to examine issues and opportunities related to catchments, consumer access to services, streaming and components of care in the future system.

We have chosen to convene a panel on this particular topic given its foundational importance to the structure and organisation of the mental health service system and the fundamental differences this can make for consumers, carers and their families.

One configuration question before the Commission is how the future system might provide consumer-centred coordinated experiences for people. The need for increased integration and coordination between services was repeatedly expressed throughout the Commission's community consultations.

For example, as one participant described at our Shepparton consultation:

> *It can't just be about funding. We need to look at the systems as well as the people, how do we integrate that better? How do we cement systems? If connections rely on individual people and their relationships, once you've lost those people the connections fall away and you have nothing.*

As described by a mental health consumer in Star Health's submission to the Commission:

> *Community health means to me that I can access a service in one place for all my health needs; it provides a continuity and familiarity which is of pivotal importance particularly when one has reached senior status.*

Another critical configuration question for the Commission is which services should be local, regional and state-wide. The Commission recognises, whilst there is a need to ensure services are locally available and accessible for consumers across all of Victoria, it is not always possible to do this and provide sufficient specialisation and expertise for consumers with less common and more complex needs.

The Commission appreciates the difficulties associated with travel and the need to reduce this for consumers, their families and carers where possible. As described by Bendigo Health in its submission to the Commission:

> *For patients and their families/carers, living in rural and remote areas of Victoria, access to Melbourne based services incurs significant family dislocation, costs associated with travel, accommodation and lost income and removes the sufferer from the social and service supports within their local community.*

At the same time the Commission recognises that, to access some mental health services, travel will be necessary and beneficial for people to receive more

1 specialist care.
2
3 Delineating between these services, which services are
4 required locally and which services will be more
5 effectively delivered on a regional or state-wide level,
6 enabling access to the latest research and credible mass of
7 expertise, is one of the many challenges that the
8 Commission and the Victorian Government face.
9
10 The third configuration question pertains to the role
11 of catchments in the future system, both from a consumer
12 and carer perspective and from the perspective of
13 governance and commissioning.
14
15 The Commission has heard from individuals who would
16 like catchments in their current form to be removed to
17 allow more consumer choice. For example, as described in
18 John Richard Newton's witness statement:
19
20 People should have the right to choose
21 where they access mental health care, just
22 as consumers of other health services (for
23 example, orthopaedic or cancer services)
24 are allowed to choose.
25
26 Others have argued for alignment of catchment
27 boundaries for the purposes of improved navigation and
28 service planning, and others focus on the important role
29 catchments currently play in requiring health services to
30 provide care to consumers who may otherwise miss out.
31
32 These issues are complex and today's panel is just one
33 way that the Commission is conducting its enquiries on
34 these matters.
35
36 In addition to today's discussion, the Commission has
37 undertaken significant consultation and engagement with
38 consumers, families and carers and will continue to do so
39 in the coming months.
40
41 Finally, on behalf of my fellow Commissioners, I want
42 to again extend my gratitude to Dr Margaret Grigg, Julie
43 Anderson and Peter Kelly; your statements canvass a range
44 of views, insights and ideas for the future and we look
45 forward to hearing from you further.
46
47 I will now ask Senior Counsel Assisting, Stephen

1 O'Meara QC, to provide some opening remarks before we
2 formally begin the panel. Stephen.
3
4 MR O'MEARA: I would like to commence by thanking the
5 Chair for her introductory remarks and the Royal
6 Commissioners and the Commission staff for identifying the
7 important topic that is the subject of today's discussion.
8
9 As you already heard, today's topic is entitled
10 service configuration. This topic directly embraces issues
11 at the heart of the deliberations of the Commissioners
12 during this phase of the Commission, leading as it does to
13 the preparation and publication of the Commission's final
14 report in early 2021.
15
16 The topic is very much at the heart of the
17 Commission's work, principally because the configuration of
18 the mental health system in Victoria is fundamental to its
19 efficacy and accessibility to all Victorians through the
20 coming decade and beyond.
21
22 This Commission is very much focused upon the
23 configuration of a system that's both robust and
24 recovery-focused in order that all Victorians may be able
25 to access and enjoy the benefits.
26
27 The Chair has already outlined some of the critical
28 issues of significant interest to the Commissioners and
29 indeed to the Commission, and I should probably identify in
30 broad terms some of the further issues to be considered and
31 discussed by today's panel.
32
33 The first is the role and distribution of different
34 types of treatment, care and support in any forward-looking
35 system supporting the mental health of all Victorians. The
36 second is the role of hospitals. The third is the need for
37 services between bed-based or hospital services and the
38 provision of primary care.
39
40 The fourth is the role of hubs or, as otherwise
41 described, community-based mental health services. The
42 fifth are the components of care in the different parts or
43 areas of the mental health system.
44
45 The sixth is the extent to which mental health
46 services may be streamed and in what particular service
47 context, and the seventh is the role of catchments and

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1 associated issues such as governance and funding.
2
3 At this point I should introduce and commence by
4 thanking our panel members in advance for their time,
5 enthusiasm and generosity in this process. Without the
6 contribution of the many witnesses, including today's panel
7 members, the Commission could not progress.
8
9 In no particular order then, I should commence by
10 referring to the first of our panel members who is Julie
11 Anderson. Ms Anderson is a Senior Consumer Advisor in the
12 Office of the Chief Mental Health Nurse and Office of the
13 Chief Psychiatrist in Victoria. She has a lived experience
14 of recovery and lived experience in working and in clinical
15 and mental health community support services.
16
17 She had long experience at very senior levels of Neami
18 National and, in 2015, sat on the Expert Reference Group
19 for the Commonwealth Government's response to the National
20 Mental Health Commission's review of mental health
21 services.
22
23 Our second panel member is Peter Kelly. Mr Kelly
24 qualified as a registered nurse in 1992 and has been the
25 Director of Operations for NorthWestern Mental Health since
26 2005. NorthWestern Mental Health is Victoria's largest
27 publicly funded mental health service. It provides
28 services to approximately 1.4 million Victorians in the
29 northern and western suburbs of Melbourne. Its services
30 are organised into six local area mental health services
31 and programs spanning 32 sites. NorthWestern Mental Health
32 also provides a number of sub-specialities.
33
34 Our third panel member is Dr Margaret Grigg. Dr Grigg
35 is the Chief Executive Officer of Forensicare, also known
36 as the Victorian Institute of Forensic Mental Health. She
37 has a PhD in psychiatry. Dr Grigg has worked as the
38 Executive Director of Health Service Policy and
39 Commissioning in the Department of Health and Human
40 Services and as Director of Mental Health in that
41 Department. She's also worked in the non-Government sector
42 having served as the Deputy Chief Executive of Mind
43 Australia.
44
45 On behalf of the Commission, may I extend a warm
46 welcome to each of our panel members this morning.
47

1 I should mention that each member of today's well
2 qualified panel has prepared a detailed witness statement
3 in response to questions posed by the staff of the Royal
4 Commission. In due course those statements will be made
5 available via the Commission's website. Each member of our
6 panel will now confirm that they will be giving evidence
7 today just as if we had been assembled at a hearing
8 face-to-face, and I might just ask, Ms Anderson, if you
9 could confirm that first?
10
11 MS ANDERSON: Yes, that's correct.
12
13 MR O'MEARA: Then Mr Kelly.
14
15 MR KELLY: (Indistinct).
16
17 MR O'MEARA: Yes, you're on now.
18
19 MR KELLY: Yes.
20
21 MR O'MEARA: And, Dr Grigg, you can do thumbs up, if you
22 like.
23
24 DR GRIGG: (Thumbs up).
25
26 MR O'MEARA: Very good, thank you everyone. Might I
27 commence by thanking you all for your lengthy witness
28 statements which have covered a range of important issues
29 in this, as has been described both by the Chair and I,
30 critically important issue in the deliberations of the
31 Commission.
32
33 In those witness statements it's apparent that there
34 are some areas of broad agreement between you. I might
35 commence by outlining some of those areas of agreement and
36 get each of you to speak in turn concerning some of those
37 areas in order that the broad areas of agreement are
38 apparent both to the Commissioners and those who come to
39 watch this panel hearing evolve.
40
41 The first is that, in the design and configuration of
42 any system for the support of people living with mental
43 illness, it's important to focus upon facilitating recovery
44 as that's the ultimate objective.
45
46 Dr Grigg, I might ask if you could just both confirm
47 that and speak to it briefly, if you could.

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1
2 DR GRIGG: Certainly. Could I just also begin by
3 acknowledging the traditional owners on the land in which
4 we meet, and pay my respect to Elders past, present and
5 emerging. I'd also like to acknowledge and pay my respects
6 to everybody with lived experienced and reflect that that's
7 the purpose and point by which we are having today's
8 conversation.
9
10 The third thing I'd like to do is a mild correction
11 about my PhD. My PhD is in philosophy and was done through
12 the Department of Psychiatry, just so nobody has any
13 misunderstanding about my credentials.
14
15 Look, I do think that the issue of recovery is very
16 central to thinking about the future of the system. When I
17 talk about recovery, I'm not really talking about clinical
18 recovery, I'm not talking about how effective our
19 treatments might be in removing people's symptoms, although
20 for many people that's the important part.
21
22 Really, when I think about recovery I think about
23 personal recovery; I think about people living as much as
24 possible the lives of their own choosing; people living in
25 ways that find meaning for them whether or not they have
26 symptoms of what we might call a mental illness, which I
27 think is really important and very important both in the
28 context of really thinking about, this is about the lives
29 of people and people themselves should be determining what
30 those lives look like, and so, the important considerations
31 of a broader psychosocial health and human service system
32 is important to achieving those recovery elements as
33 considerations of how we might organise our more kind of
34 limited tertiary health system.
35
36 MR O'MEARA: Thank you. The second area of broad
37 agreement concerns the self-management of mental illness
38 and its support with a range of supports, not merely as,
39 Dr Grigg, you've identified, medicalised care or clinical
40 care, but also psychosocial supports and perhaps the
41 support of psychosocial coaches.
42
43 Ms Anderson, you've got a lived experience of recovery
44 as we've heard, but also have some views about the supports
45 that can be provided to people living with mental illness;
46 we might be able to get you to speak to that broad area of
47 agreement between the witnesses.

1
2 MS ANDERSON: Thanks, Stephen. I think recovery is
3 supports, connectedness, meaning, empowerment and hope, and
4 for that I think there needs to be connected systems, not
5 just around clinical recovery but around the psychosocial
6 supports of recovery; that supported my recovery journey,
7 taking the clinical perspective together with the
8 psychosocial supports around budgeting, house cleaning,
9 shopping, looking after children; they were just as
10 important as my clinical recovery.
11
12 MR O'MEARA: Thank you. The third area of broad agreement
13 is that the present system between the hospital acute
14 system on the one hand or bed-based system on the one hand,
15 and the primary care system on the other hand has a degree
16 of fragmentation in the service delivery, and that too
17 often people come out of a hospital admission and fall back
18 on the care of a GP, if at all.
19
20 Mr Kelly, might I be able to ask you to speak to that
21 particular problem about which there's general agreement.
22
23 MR KELLY: (Inaudible).
24
25 MR O'MEARA: I can't quite hear you yet.
26
27 MR KELLY: I'm unmuted on my system.
28
29 MR O'MEARA: There you go.
30
31 MR KELLY: Okay, thank you. Yes, we spoke about this in
32 the conclave last week. I think there is a gap between
33 hospital-based and community-based care and that in the
34 wider community, in the primary care setting. The mental
35 health system, frankly, is overwhelmed with demand and is
36 forced into a throughput system, if I can put it that way.
37
38 We are providing care for about the top 0.9 or
39 1 per cent of people with a serious mental illness rather
40 than the 2 to 3 per cent that is widely accepted as
41 appropriate in a health system such as Victoria's.
42
43 You know, people come into hospital pretty acutely
44 unwell and leave pretty acutely unwell, and we're relying
45 largely on the community mental health system and the
46 primary care system to provide care and support for those
47 people, and at times that system is under severe duress.

1
2 MR O'MEARA: Thank you. The next and fourth area where
3 there's been broad agreement between today's witnesses
4 concerns the value in streaming of care and, indeed, the
5 ways and some quite innovative ways in which that might be
6 approached by the creation of cohorts or pods in a hospital
7 setting.
8
9 Dr Grigg, you've expressed some views concerning that,
10 I wonder if you might be able to address that issue for us.
11
12 DR GRIGG: Well, look, I think streaming of care is an
13 important design principle. There's already a degree of
14 streaming by aims; there is streaming by some diagnostic
15 groups, particularly when they've got very specific models
16 of care such as eating disorders.
17
18 I think that, as a panel discussion, certainly what I
19 took away from that discussion without wanting to commit to
20 reference any of my other panel members, is all of us
21 thought that more could be done with streaming.
22
23 I am certainly a very strong advocate for stronger
24 gender-based streaming and certainly it's one of our
25 objectives in thinking about the future of Thomas Embling
26 Hospital, that what we don't have is a model of care and
27 stream that effectively speaks to the needs of women.
28
29 But I think the other area of streaming that we've had
30 a long conversation about that was really important was
31 thinking about those people with complex needs, substance
32 abuse, maybe higher levels of occupational risks of
33 occupational violence, and how they're streamed with
34 perhaps more vulnerable people. And so, some of the worst
35 stories of vulnerable, sometimes older consumers being
36 physically assaulted in inpatient units, adult inpatient
37 units, where the mix of patients is so broad that it really
38 is impossible to meet everybody's needs and create a safe
39 environment.
40
41 While I think that we balance that off with a bit of a
42 discussion about also watching issues of stigma in the way
43 in which we stream, and also my concerns that a system
44 design is able to speak to the needs of people in rural and
45 regional Victoria as much as it's able to speak to the
46 needs of the people in more densely populated areas of
47 Melbourne.

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1
2 MR O'MEARA: Thank you. Can I raise, just before I move
3 to another element of the streaming issue, a particular
4 issue with you and it's not so much a streaming issue as
5 the access to specialist support issue. You have some
6 experience with the Partnership Project and the importance
7 of general practitioners having access to specialist
8 support in order to provide better care.
9
10 Within that is an issue about the extent to which, and
11 I guess streaming might be part of this, the extent to
12 which specialisation can give rise to better care and, for
13 that matter, general practice can be supported by
14 specialisation. Might I just ask you to speak to that
15 briefly before we move to the final issue of streaming and
16 specialisation.
17
18 DR GRIGG: Certainly and the Partnership Project was a
19 jointly Federal and State funded project that sought to
20 strengthen the relationship and linkages between
21 state-funded services by the Victorian Government, private
22 facilities and our partnership was with Healthscope
23 particularly the Melbourne clinic and, thirdly, general
24 practitioners.
25
26 And, what we're looking at was looking at particularly
27 innovative funding options that were able to provide
28 greater support to general practice, so GPs were able to
29 ring and get early advice around consultation; it helped us
30 support general practitioners to make referrals into a
31 cohort of private psychiatrists, but we also work with the
32 private hospital to think much more about which patients we
33 were caring for in a private hospital environment.
34
35 Our data showed us actually our patients had a higher
36 rate of private health insurance than we thought, although
37 this is the 90s where generally more people had private
38 health insurance anyway, but we were able to work quite
39 closely in that kind of connected model of care with a
40 private hospital, and in many ways it goes to opportunities
41 around innovation in our local area about how you can
42 create connections between parts of the service system that
43 traditionally don't operate together because they operate
44 in quite separate funding streams, leaders, and policy
45 environments.
46
47 MR O'MEARA: Thank you. Just before we move away from the

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1 topic of streaming, Ms Anderson you've identified a
2 difficulty that can arise in a streaming approach, I wonder
3 if you can just speak to that.
4
5 MS ANDERSON: Yeah, Margaret touched on it briefly around
6 stigma. I think the streaming through illness can be
7 stigmatising for people with mental illness. Some
8 illnesses hold more stigma than others, such as borderline
9 personality disorder, so I think it is an opportunity to
10 develop specialist areas, but I think streaming through
11 aged, mother-baby and adult is a better way to go rather
12 than streaming through illness because of that stigma
13 question.
14
15 MR O'MEARA: Thank you. Just before we move away from
16 streaming, I might ask Mr Kelly an issue which arises, and
17 it might not necessarily be an issue of broad agreement,
18 but is it the position that streaming gives rise to better
19 quality of care or can give rise to better quality of care
20 and, if so, in what contexts?
21
22 MR KELLY: Well, it can give rise to better quality of
23 care and better access to care, and I'll give you a recent
24 example.
25
26 There's a niche service at the Royal Melbourne
27 Hospital called the Deep Brain Stimulation Service and the
28 Young-Onset Dementia Service. The Young-Onset Dementia
29 Service was funded through a grant, a one year grant
30 through Safer Care Victoria. It provided access to an
31 assessment service right across Victoria. So, you know, in
32 Wangaratta and Mildura and so on consumers were able to
33 access that service, and really they got a fantastic
34 service and it dealt with all the issues you raised in your
35 introduction about accessing services in the city, costing
36 money, costing time, being inconvenient, creating a
37 logistical burden and being unfriendly for carers and
38 consumers.
39
40 Both these services have been recurrently funded by
41 the State Government as recently as three weeks ago, and
42 that is a tremendous opportunity for people in rural and
43 regional Victoria to access highly, highly specialised
44 services in the area of deep brain stimulation and
45 Young-Onset Dementia.
46
47 What we've found through that Safer Care Victoria

1 project is that telehealth options for consumers in rural
2 and regional Victoria are highly palatable for all the
3 reasons I just mentioned. So, you're getting access to
4 highly specialised clinicians and a highly specialised
5 service but the reach is broad right across Victoria.
6
7 MR O'MEARA: Thank you. Just before I move away from you,
8 Mr Kelly, the final issue about which there's broad
9 agreement concerns the nature of the space, if you like,
10 between acute or bed-based care and primary care which I
11 referred to in my opening, and that, whilst you don't need
12 to necessarily dismantle the whole of the furniture that
13 might exist in that space - among other things it might
14 create confusion - but the problem is that the system's
15 been degraded.
16
17 Now, accepting that the system's been degraded, can I
18 ask you to speak to - it's one thing to recreate a system
19 from 30 years ago, but how does one create a system in 2020
20 and looking forward to 2030, what does that kind of system
21 look like briefly in order that I can then introduce -
22 might be able to then introduce - the issues about which
23 we'll be really moving to consider?
24
25 MR KELLY: I think frankly, it's - rebuild is going to
26 have to happen in two phases and the initial phase is
27 actually just trying to build some urgent capacity into the
28 system and we're starting to see that now with the interim
29 recommendations of the Royal Commission in terms of new
30 beds. So the project of 135 new beds is starting to gain
31 traction, and that bed capacity will be enormously
32 important to us in the short-to-medium term, and on the
33 back of that you've got to build community capacity and
34 some of these links between the tertiary system and the
35 primary system.
36
37 To illustrate that point I can tell you that this
38 morning at 9 o'clock we've got 31 consumers sitting in
39 three Emergency Departments that we service, so at
40 Northern, Sunshine and Royal Melbourne Health. If I just
41 talk about Northern Hospital at the moment, we've got
42 consumers sitting there at 36 hours, 20 hours, 20 hours and
43 18 hours waiting for a bed.
44
45 So, it's an outrageous situation. We've got more than
46 a full ward of consumers sitting there in a holding pattern
47 in Emergency Departments which are high stimulus

1 environments and frankly unsafe for people who are acutely
2 mentally unwell.
3
4 MR O'MEARA: How common an experience is that?
5
6 MR KELLY: It's an everyday occurrence and has been for
7 the past decade.
8
9 MR O'MEARA: And this goes to the issue that you've
10 identified, which is both the need for immediate support to
11 the system, together with proper coordination between the
12 elements in the system which we'll come to: is that
13 correct?
14
15 MR KELLY: That's correct.
16
17 MR O'MEARA: Can I move at this point to the issues that
18 have been discussed between you as panel members and
19 starting with an issue and one that you identified in your
20 discussions, an issue of, if you like, an issue that might
21 inspire optimism, and that is that the recent response,
22 community response, Governmental response, medical response
23 to the COVID-19 pandemic and that that has shown that rapid
24 change is possible.
25
26 Mr Kelly, I might just, before I move away from you,
27 ask you to speak to that because that's an issue that you
28 identified when we met last week, and if you could speak to
29 that to start with.
30
31 MR KELLY: Well, it's both a cause for optimism and a
32 cause for disappointment, I guess, in a way. What we have
33 seen with COVID-19 is, where there is a will, there's a
34 way. So, hundreds and hundreds of consumers who
35 effectively have been homeless or sleeping rough have been
36 accommodated in hotels over the past three and a
37 half months; that's an issue that seems to have eluded
38 people for the past decade and it's been a growing problem.
39
40 I also note that 200 intensive care beds were built in
41 the lead-up to COVID-19, appropriately in my view based on
42 the sort of demand we were seeing in other parts of the
43 world for intensive care beds. However, none of those beds
44 have been used. The accepted wisdom is that it costs
45 $1.1 million to build an intensive care bed, yet for the
46 past decade we've been advocating for more acute beds and
47 essentially those appeals have fallen on deaf ears.

1
2 MR O'MEARA: Thank you. Can I move, having introduced it
3 in that way, and you've identified the need for funding, to
4 the need to approach the design of a new system.
5 Ms Anderson, can I ask you to speak to the issues of
6 co-design which you've identified in the discussions
7 between the panel members, and the role of consumer choice;
8 if you could commence by introducing those issues and then
9 I'll ask the other panel members also.
10
11 MS ANDERSON: I think with the National Mental Health
12 Standards that the services partner with consumers very
13 well, it's a standard that they're accredited with, but I
14 don't think we know how to co-design or co-produce
15 effectively, and I think that's a capacity that needs to be
16 built into services around that co-design. There's some
17 very good UK tools around how to embed co-design into
18 service delivery.
19
20 And consumer choice, I think the choice around what
21 services you receive and when is very important. I think
22 you should be able to have the choice to have treatment and
23 care in the home, not just in the hospital system, and I
24 think that the choice around that treatment and care is
25 really vital to a recovery journey.
26
27 I don't agree on seclusion and restraint and services
28 that provide seclusion and restraint.
29
30 MR O'MEARA: Just before we move to an issue related to
31 that, I might just ask our panel members to agree - to
32 either indicate that they agree with what Ms Anderson said
33 or maybe contribute something to that topic themselves if
34 they wish.
35
36 MR KELLY: Which part?
37
38 MR O'MEARA: The issue of either co-design or consumer
39 choice.
40
41 MR KELLY: I fully support consumer choice and I fully
42 support consumer design and I agree with Julie that it's an
43 iterative process, I guess, it's around mental health
44 clinician literacy around co-design.
45
46 I could give a couple of examples where we've done
47 that recently and done it very well; one around the youth

1 PARC that will be built at Poplar Road in Parkville, and
2 the other women's PARC that will be built at Sunshine
3 Hospital.
4
5 MR O'MEARA: Thank you, and Dr Grigg?
6
7 DR GRIGG: Look, I do. I think Julie rightly points out
8 some of the technical and skill issues around co-design.
9 But I do also think that it's a cultural issue. I think
10 that it's a really, really important cultural issue in
11 what's a professionally dominated sector, how we really
12 engage. And there will be some people who talk about this
13 issue of where you're prepared to share power with people,
14 being able to share control.
15
16 And I do think that it's important and incumbent on
17 services such as ours to be able to tackle the hard bits of
18 it as it reflects in the culture, as well as develop up
19 particular skills and tools and workforce in order to be
20 able to really effectively kind of partner and design
21 services for the people who are intending to use them.
22
23 MR O'MEARA: Thank you. Ms Anderson, I might return to
24 you because you raised the issues of restraint and the
25 like. You've expressed views in your statement concerning
26 the limited, if any, role of hospitals; I might ask you to
27 address that issue as we move to consider the role of
28 hospitals in a system.
29
30 MS ANDERSON: I think the role of hospitals at the moment
31 is around the episodic nature of illness, I don't think it
32 really supports an ongoing recovery journey. I think in
33 some instances the hospital has a role of containment
34 rather than a place of care and healing.
35
36 I think, with all the good intentions of workers, I
37 think that they're in an impossible situation as well, that
38 there's the episodic nature, they don't see people in a
39 recovery journey. I think it's really a home-like
40 environment or being at home is more conducive to recovery.
41
42 MR O'MEARA: Thank you. Going back to you, Dr Grigg, can
43 I ask you to speak to the role of hospitals in a future
44 system, if you could.
45
46 DR GRIGG: I suppose fundamentally it depends on what we
47 mean by the concept of "hospital" and whether a hospital

1 encompasses any bed-based congregate care setting, which is
2 the position I'm going to take on that a little bit.
3
4 I think that there's - I would cluster it into
5 probably three main clusters. The first is, there is, and
6 will continue to be, a need for tertiary hospital-based
7 care; whether that's about assessment, whether that's about
8 ability to access diagnostics that you're not able to
9 deliver in the home, whether that's about really close
10 monitoring.
11
12 The second part of that is, I think that there is a
13 need for hospital-like care that gives some sense of
14 respite and sanctuary to people for a period of time. I
15 think our PARCs hold the aspiration of being the most like
16 that.
17
18 Certainly, there are people that I talk to for whom
19 just having a period where, a period out from their life
20 for a period of time, is an incredibly important part of
21 their healing, that that really needs to occur in an
22 environment that is very, very recovery-orientated.
23
24 The third part of, whether we call it hospital care or
25 not, is the issue of extended care; of people who, for
26 whatever reason, are going to need to sit in some form of
27 bed-based service for often quite extended periods of time;
28 whether that is because they really are unable to manage on
29 their own, whether that's actually about a management of
30 problematic behaviours, high levels of need for personal
31 care - there's a few reasons for it, but in its broad sense
32 if I think about hospital care as congregate-based,
33 bed-based care, I think that there is an ongoing need.
34
35 I think what the system currently doesn't do is two
36 things: provide people with the option and choice, so
37 they're receiving their care in the right place at the
38 right time and, secondly, provide that care in a way and a
39 manner for the length of time that best matches that
40 person's needs.
41
42 MR O'MEARA: Thank you. Mr Kelly, you've spoken about the
43 crisis and containment role of hospitals in the present
44 time; how might that be re-imagined and the role of
45 hospitals seen accordingly?
46
47 MR KELLY: Well, it's interesting, isn't it? If I do a

1 meander down memory lane to when I was an undergraduate
2 student in the late 1980s the average length of stay was
3 closer to six weeks in an acute hospital bed. In fact on
4 the weekends on a 25 bed ward we'd be lucky to have six or
5 seven consumers actually in the ward; everyone else was
6 home on weekend leave or overnight leave.
7
8 These days the length of stay is closer to nine days,
9 we don't have any leave whatsoever. We're a 503 bed
10 service and I can assure you that, with the exception of a
11 couple of vacancies in our aged acute beds at the moment,
12 every single bed is full.
13
14 So, you know, and what we're trying to do today is
15 find capacity for those 31 consumers sitting in the three
16 EDs. So, there's certainly a thing about capacity but
17 there's also the way the services function, the way they
18 look, the way they feel, how therapeutic they are, and
19 picking up on Julie's points, how they provide a
20 recovery-based service to people in what is a relatively
21 narrow cross-section of their lives for a nine day
22 admission.
23
24 I don't share the view that hospitals are just about
25 containment, I think an acute admission serves many more
26 functions than simply containing someone. It can be about
27 containment, but it's often about family respite, it's
28 often about providing an opportunity for a longitudinal
29 assessment over days rather than minutes, it's about
30 commencement of treatment, and it's about providing
31 treatment in a setting that can't be provided in a less
32 restrictive setting such as ECT for instance, to some
33 people.
34
35 MR O'MEARA: Thank you. Can I ask you, because you have
36 experience of this in NorthWestern Mental Health, moving to
37 talk about the space between the hospital setting, if you
38 like, and the primary care setting which I referred to in
39 my opening: one way to access that space is via triage and
40 you have an experience in your own organisation of
41 telephone-based triage; I wonder if you can speak to the
42 benefits of that system and explain how that system works.
43
44 MR KELLY: As a point of access?
45
46 MR O'MEARA: Yes.
47

1 MR KELLY: NorthWestern Mental Health aggregated its
2 various triage components probably about 10 or 11 years ago
3 now for efficiency and for consistency reasons; it
4 coincided with the State Government introducing
5 standardised triage scales. So, we aggregated our triage
6 services into a centralised triage model that's based at
7 Royal Park, and it deals with about 100,000 incoming and
8 outgoing calls per year. So, it is the first point of
9 contact both for consumers, for primary care physicians and
10 for consultant psychiatrists, or indeed, carers.
11
12 We have set up a couple of VIP numbers so that people
13 can - GPs for instance are not placed in a queue or waiting
14 for a call, they can receive access more immediately, and
15 we utilise the state-wide triage guidelines to determine
16 service response for whoever makes contact with that
17 service.
18
19 MR O'MEARA: From that service, how is it then determined
20 to where the consumer might be placed?
21
22 MR KELLY: At the moment it's based on geography, your
23 residential address.
24
25 MR O'MEARA: Thank you. Moving to the alternatives to
26 hospitals in that space between hospital care or that form
27 of bed-based care and primary care, there's been reference
28 in the statements to notions of hospitals without walls or
29 hospital in the home; Ms Anderson, can I ask you to speak
30 to that kind of model and how you would see that kind of
31 model having benefits?
32
33 MS ANDERSON: Yeah, I alluded to hospital without walls
34 because hospital in the home for people with mental health
35 issues, often hospital relates to trauma and bringing that
36 trauma into the home is not conducive to recovery.
37
38 So, I think people can - that teams come into the home
39 and support people even in their acute phase of illness,
40 and I think that there can be home-like environments such
41 as PARC for people to have some of that sanctuary away from
42 their daily lives. But rather than disrupt a person's life
43 with a hospital stay, I think it's more conducive to
44 recovery to support a person through what they're going
45 through in their own environment, to come back to that
46 environment and to support their recovery.
47

1 MR O'MEARA: What do you see as the elements, the
2 supportive elements, in that kind of model? Is it beyond
3 medical care and, if so, what kind of other forms of care
4 is it? Is it the kinds that you spoke of earlier that you
5 have personal experience of, or is it beyond that entirely?
6
7 MS ANDERSON: I think it can be medical care, it can be
8 people need to know that their physical and mental health
9 is stable. I think it's around some of the psychosocial
10 supports around, one, well, the most basic need is having a
11 house, and around budgeting and things that are difficult
12 while you're at home; even opening the mail can be a
13 difficult thing, so a psycho community - a mental health
14 community support person is part of the team as well as
15 clinical clinicians in the team.
16
17 MR O'MEARA: And is this something, Ms Anderson, that you
18 see as having value in the bed-based services as well as
19 other settings?
20
21 MS ANDERSON: In the home-like environment such as PARC I
22 don't think any person - if they go to hospital for a
23 physical illness, it disrupts their lives; if you add the
24 mental illness on top of that, it's just - it's hard to
25 recover from: you're recovering from the hospital stay as
26 well as a personal recovery journey; it just adds another
27 burden onto a person's recovery.
28
29 MR O'MEARA: Thank you. Dr Grigg, we've rather moved into
30 the architecture of what might be a system between the two
31 disparate ends of it that I've described, but you've
32 expressed some views about the guiding principles that
33 might be embraced before one even begins to see how those
34 bits of furniture might be oriented between; I wonder if I
35 can ask you to speak to those principles.
36
37 DR GRIGG: I hope that you're referring to actually
38 ensuring the kind of cluster of the sort of four things I
39 thought we needed to ensure are available.
40
41 So, there is access that people need to healthcare;
42 there are healthcare interventions that should be
43 delivered; whether that's the medical treatment, you know,
44 assessment tests, medication, but actually also
45 increasingly the large evidence we have around
46 effectiveness of psychological treatments.
47

1 There are a whole range of psychosocial needs that
2 people have, I think Julie referenced it when she talked
3 about a very basic one was housing. I might just talk
4 about stable and safe housing as well as not just
5 necessarily any roof over your head but, you know, your
6 ability to have food on the table, your ability to do your
7 washing, open your mail as Julie referred to, a whole set
8 of psychosocial needs that need to be met.
9
10 I think the third one I referred to really related to
11 those issues around occupational function. We all need
12 meaning and purpose. Depending on the nature and phase of
13 our illness, how much of that we can tolerate may vary: for
14 some people it may simply mean finding a purpose to get out
15 of bed in the morning; for other people it might be really
16 active job-seeking that becomes really important. So,
17 purpose, meaning, occupation is a critical component of any
18 system design.
19
20 The fourth one I talked about was relational: we need
21 people in our lives, we need to be in environments where we
22 mix and talk with others. And, I think, as we think about
23 the kind of care place and the care journey, thinking about
24 what components all of these four elements bring and what
25 their various mixes are, there might be phases of your
26 illness where, you know, 70 per cent of it's sitting in the
27 medical domain, but equally there may be phases of your
28 illness where actually most of the question is, how do I
29 find purpose for my life or how do I build and grow
30 meaningful relationships.
31
32 And that hooks and connects back to my opening
33 statement that recovery for people needs and must be more
34 than just access to healthcare, whilst still acknowledging
35 that healthcare will play a role in that.
36
37 MR O'MEARA: Thank you. Accepting, as we must, that those
38 four concepts have all got a role to play and there might
39 be a difference in what weight is given to each of those
40 concepts in different parts of the system, I suppose if we
41 drill into that, in a system of limited resources and in a
42 system where we have to treat more than one person, and a
43 system where different people come into the system and
44 hopefully progress through recovery, what kind of emphases
45 would those concepts - or should they be given at different
46 points in the system between on the one hand hospital, on
47 the other hand primary care, and in between? Is it

1 possible to say that?
2
3 It's very difficult - just before I move into it and
4 ask you the question - it's very difficult of course and
5 expensive to have a system which creates that full volume,
6 each of those availabilities. How is it to be rationed?
7
8 DR GRIGG: Absolutely, absolutely and, you know, I think
9 that they do become questions of design. I suppose that
10 one of the reasons it's really important for me to
11 emphasise the psychosocial, the occupational and the
12 relational elements, and some of these things don't
13 necessarily cost any money. The evidence is that it's
14 actually informal relationships, it's how do I make
15 friends.
16
17 A common question you might ask somebody could be, "If
18 you've got a problem who would you talk to?" How we might
19 support people to be able to widen out and develop their
20 friendship networks is a really, really important part of
21 recovery, and it's not actually something that costs much
22 money.
23
24 Here, for example, I want to call out the work of an
25 organisation such as VMIAC that's been doing great work
26 at - it's not just their advocacy platform, it's not just
27 the sort of practical help seeking that they're doing, but
28 actually they're a really important organisation for people
29 to find identity, meaning and relationships in, and that's
30 not necessarily about spending a lot of money in doing it.
31
32 Pretty similarly, if I pick up the ways in which we
33 might think about actually ensuring that we've got pathways
34 into employment, the reality is that many of our employment
35 schemes are quite hard and difficult for people,
36 particularly people with severe mental illness, to actually
37 navigate.
38
39 When I was at Mind Australia we were doing a project
40 with some employment providers to really help people think
41 about and engage in meaningful activity because employment
42 both gives us structure, it gives us purpose, but it's
43 probably one of the most powerful pathways out of poverty
44 that our patients will face, and yet, we don't give enough
45 thought to what are the system design issues that encourage
46 and interface into the employment placing.
47

So, what I would suggest to the Commission, that some of these aren't all necessary - you know, building more beds, having more workers, are very expensive; but sometimes actually just thinking about navigation, small adjuncts to systems. There's been - I'm aware of some services, for example, who have found room for employment consultants within the area of mental health services to really support employment outcomes; a relatively cheap and very effective intervention for actually supporting people's recovery.

So, I do think that this speaks and connects to both the issue of system integration and system navigation because, if we get the design right, we can leverage off what's already there for people, not necessarily replicate or spend a lot of money doing it.

MR O'MEARA: Thank you. If I could ask you just one further hard question, I apologise that it's hard, but if accepting that supports to do with enabling people to develop vocational skills and access to employment and so on can be very important, and if it can't be that it's at every point of the system where there's access to that - and you've referred to the fact that employment consultants - you're aware of an employment consultant being available in a particular area of a mental health service, is that the proper place for that kind of support? If you couldn't have that kind of support everywhere, where's the best place for it?

DR GRIGG: Look, it would really surprise you: we have people who are currently within Thomas Embling Hospital going out to work. Inpatients at Thomas Embling Hospital who have jobs. Equally, in some of our consultant work we are increasingly looking at the use of current patients of ours, paying them as consultants to do work for us.

Of course it's easy to see that the proportionate people further down the chain, if you like, there's more opportunity, but certainly if I were working with young people it probably wouldn't matter how sick that person was, the issue of either education or employment, keeping meaningful purpose would have to be absolutely essential to the work that we do. Spending 40 years on a disability support pension really has terrible kind of long-term outcomes at least in the area of poverty and your ability to engage in a kind of community.

So again, I think that there are opportunities for us within a healthcare setting, and I don't want to diminish - you know, I probably sell healthcare for a job, you know, I run a hospital, I run tertiary services and they're important and they're expensive and we need them, but we need a system design that recognises across all of that continuum that people's lives are more and people need more than just access to healthcare.

Perhaps that was one of the most important lessons five years in an NGO really taught me, and it taught me a lot more about the capabilities of people and, again, this is where I want to speak back to the culture of it, the culture of mental health services where sometimes our beliefs in what we think people are capable of doing and the lives they're able to live are really kind of overshadowed by our own sense of negativity; our own sense sometimes of the hopelessness of the churn of people through acute systems. I've seen 31 people sitting in an Emergency Department in acute need; for me, looking at very unwell prisoners sitting in prison who we're unable to provide effective treatment for.

One of the other really important aspects of recovery, this concept of hope, is a really important concept I think to actually apply to our system. And, for me, one of the important opportunities of the Commission is its ability to give hope to those of us within the system so that we can see that it's possible for people to live different lives to the lives that they're living today.

MR O'MEARA: Thank you. Mr Kelly, moving to you: your statement talks about the continuing care model versus the episodic care model, and you also have experience of a model in New Zealand which provides five levels of support: if I might ask you, in talking about that space between hospitals on the one hand and primary care on the other, if you could speak to both of those concepts.

MR KELLY: Slowly, please (inaudible).

MR O'MEARA: I think you might be muted again.

MR KELLY: (Inaudible).

THE CHAIR: We can't hear, sorry, Stephen and Peter.

1
2 MR KELLY: Can you hear me now?
3
4 MR O'MEARA: Yes.
5
6 THE CHAIR: Yes, thank you.
7
8 MR KELLY: I've done nothing, someone's muting me
9 off-site.
10
11 THE CHAIR: That might be us, I suspect, so Heather and
12 the team will keep an eye on that.
13
14 MR KELLY: Thank you. I've lost my train of thought, the
15 first part of the question?
16
17 MR O'MEARA: The first part of the question was, the
18 observations that you've made concerning NorthWestern
19 Mental Health's experience of the continuing model of care
20 as opposed to the episodic model of care which you've
21 described in your statement as harmful, and that being a
22 model of care which you have experience of and can speak
23 to, and you've also spoken in the conclave concerning your
24 observations of the system in New Zealand which has five
25 different levels of care, which they're not the same thing,
26 but I'd like you to speak to both of those topics, if
27 possible, in this general setting of, how does one approach
28 what needs to happen between hospitals on the one hand and
29 primary care on the other.
30
31 MR KELLY: Okay. It's probably helpful to go back to the
32 early 1990s which was probably recognised as the sweet spot
33 in the Victorian mental health system where it appeared at
34 least to be adequately funded and adequately resourced to
35 do its job. At that time the community clinics, the adult
36 community clinics, were known as Continuing Care Teams
37 because they provided continuing care.
38
39 But over time as the population has grown and services
40 have become overwhelmed, we've had to move towards an
41 episodic care model, and what that means is that people
42 cycle through that clinic, or our clinics in a sort of
43 acute unwell, recovery, stability, relapse, recovery sort
44 of cycle, and for people with a severe and enduring mental
45 illness that is harmful, because particularly for people
46 with psychotic disorders, each time a person has a
47 psychotic breakdown that individual experiences a minor

1 cognitive decline, and each of those cognitive declines
2 build one upon the other and over time degrade the person's
3 level of functioning.
4
5 So, we've moved to an episodic model not out of desire
6 but out of need to try to do the most good for the most
7 people, and what that means is that each week or each month
8 or each year we have to have the same number of people
9 exiting the clinic or the caseload as have entered,
10 otherwise the inevitable outcome is you end up with a wait
11 list system which we've never embraced because I think that
12 just is a sort of harmful space for people to be in as
13 well.
14
15 So, I suppose what I'm saying is that, the old system
16 of continuing care recognised that people who had a severe
17 and enduring mental illness often needed lifelong care, or
18 at least longer than they get now under the episodic care
19 model.
20
21 MR O'MEARA: Thank you. You've observed in New Zealand -
22 sorry, before I move to that: you've observed that part of
23 the problem is, once episodic care has been provided by
24 your service, often a consumer will then plummet, if you
25 like, back into the hands of the GP at best and that's the
26 difficulty in the space that I've described between
27 hospital on the one hand and primary care on the other, and
28 you've observed a system in New Zealand which has five
29 levels of care; I wonder if you can speak to how that
30 works?
31
32 MR KELLY: The New Zealand model particularly related to
33 consumers with a severe and enduring mental illness who
34 needed residential care support, so it was specific to that
35 area where people, mostly who had schizophrenia or
36 long-term bipolar affective disorder that needed support to
37 move into independent living graduated through a system,
38 Level 5 through to Level 1. Level 5 was akin to sort of
39 our community care units here in Victoria, where there was
40 24-hour staff, through to Level 1 which was effectively
41 independent living with in-reach from a non-clinical
42 provider, and that system seemed to work effectively when I
43 worked in New Zealand back in the late 1990s, early 2000s.
44
45 MR O'MEARA: Can I just get you to populate the fourth,
46 third and second levels as well.
47

1 MR KELLY: They were just graduated levels of support, so
2 apart from having, you know, if you take the CCU example
3 where you've got staff on site 24/7, you might move to a
4 system where you have staff working two shifts with a
5 sleepover, and then one shift, and then a group of
6 consumers living in a block of flats for instance that had
7 been converted for this purpose, with in-reach into that
8 block of flats, and then finally moving a person into
9 independent accommodation.
10
11 MR O'MEARA: Thank you. Before I move away from you, one
12 of the issues that's been identified, and Ms Anderson made
13 reference to it, is the idea of the hospital without walls
14 and the like treatment in the home. You made mention of
15 the 1990s and there being, if you like, assertive outreach
16 or what were then said to be called CAT teams; I gather
17 from what you've said you regard that as having been a
18 successful feature of the system at that time, albeit a
19 system that's been degraded somewhat since, but also an
20 expensive element of the system.
21
22 Before we talk about the expense of it, what about the
23 efficacy of it and the success of it, are you able to say
24 anything about that?
25
26 MR KELLY: Yeah, it was efficacious and it was very
27 palatable to consumers and carers because we were providing
28 home based assessment and treatment to people in an area
29 where they - you know, in a location where they felt
30 comfortable and supported and often had their loved ones
31 around them. Ironically the success of that program led to
32 its demise in the sense that it just couldn't keep pace
33 with the work.
34
35 I did that job for two years back in the early 1990s.
36 Initially those teams had two functions: they were doing
37 assessment and treatment, and in the end they could do
38 neither function well. We ended up with caseloads on our
39 treatment board of up to 30 or 35 consumers spread over a
40 large geographic area, and in the end it just became
41 impossible to maintain that, to maintain the quality of it.
42
43 And it was more than just dropping off and giving
44 people medication, it recognised that we were dealing with
45 people with the full gamut of mental illnesses: people who
46 had lifelong and enduring mental illness; people who were
47 having a single psychotic episode due to illicit drug use

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1 for instance; people presenting with suicidal ideation in
2 the context of a situational crisis. So, you offered the
3 full range of supports to those people to deal with a
4 crisis. They were called crisis teams for a reason, so
5 crisis theory was applied. In other words, you tried to
6 understand what the symbolic meaning of the crisis was for
7 the person, you tried to uncover their internal resources
8 and see what had sustained them in previous instances of
9 crisis, you tried to build on those and get the person
10 emerging from that with a higher level of functioning.
11
12 So, if you take the example of someone with a
13 situational crisis due to a gambling problem for instance,
14 where perhaps they were about to lose the family home, the
15 mortgage was about to be foreclosed, the marriage or the
16 relationship was starting to fall over as a consequence of
17 that, and really their whole world had started to tumble
18 down, then you start to unpack that and put in place the
19 appropriate resources, whether it's gamblers' help
20 assistance, financial counselling, relationship
21 counselling, immediate crisis accommodation if that's
22 required, as well as the medical treatment. So, it wasn't
23 like the medical treatment was the absolute focus of it, it
24 was one of a number of elements of care that was being
25 provided to that individual and indeed their families at
26 that point in their life.
27
28 MR O'MEARA: Accepting that - sorry, Peter - sorry,
29 Mr Kelly - accepting that the system that you're speaking
30 to I think conceptually is a 24/7 type system; is that
31 right?
32
33 MR KELLY: In those days in the early 90s it wasn't 24/7,
34 it ran two shifts per day seven days a week with an on-call
35 function overnight, and largely the on-call function was to
36 respond to people presenting in crisis either at police
37 stations or Emergency Departments.
38
39 MR O'MEARA: Is that an effective way of running a system
40 like that, to give emphasis to particular periods with
41 on-call at other times?
42
43 MR KELLY: What's the alternative? I've spoken this
44 morning about 31 patients sitting in Emergency Departments,
45 very busy Emergency Departments occupying resuscitation bays
46 at enormous cost, draining enormous resources, in an
47 unfriendly, unsuitable environment. So, I think it's

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1 highly cost-effective.
2
3 MR O'MEARA: How did the system operate, for example, in
4 rural or regional areas?
5
6 MR KELLY: I can't really comment on that because I was
7 based here in the inner west out at St Albans, but in fact
8 we travelled out as far as Melton, Bacchus Marsh, and up as
9 far as Sunbury, so a pretty large geographical area, but I
10 fully concede that operating in that environment is very
11 different to operating in Mildura, for instance.
12
13 MR O'MEARA: Thank you. Dr Grigg, I might go to you on
14 this topic of different innovations that can populate that
15 space between hospitals on the one hand and primary care on
16 the other, and we've been given the example of these crisis
17 assessment teams as they've been differently described. If
18 I can ask you about those while we're trying to get
19 Ms Anderson back onto the call.
20
21 DR GRIGG: Certainly. So, like Peter, I was involved in
22 crisis teams, I managed a crisis team in the inner city in
23 what I think was the early 2000s, I kind of have to do my
24 timing, it always feels a long time ago.
25
26 Look, there's absolutely no doubt that they were
27 important. There's a question of what the contemporary
28 look of them look like today which I think is important.
29 But that issue of being able to provide people with options
30 for intense treatment at home: you know, the ability, as
31 Peter's said, to actually provide a broad range of
32 interventions because they were multidisciplinary teams, so
33 you were able to provide broader psychosocial input if
34 needed.
35
36 The ability to potentially visit somebody up to three
37 times in a day, the ability to really go at all times of
38 the day, be on-call. I had a little bit of an experience
39 of the teams in rural communities and they did operate a
40 little bit differently, but often kind of really
41 effectively in terms of being able to provide, and I do
42 think that there's opportunities to learn from crisis teams
43 of which they're well-established in a whole range of other
44 jurisdictions.
45
46 We find a number of evaluations of it and think about
47 what a contemporary design of them might be if we think

1 about a hospital without walls or a hospital at home, and I
2 would say that other parts of healthcare are really
3 actively looking at these models of care, of being able to
4 deliver where possible services to a person at home rather
5 than necessarily bringing them into the hospital, so I see
6 that they have to be a really important part of some future
7 design.
8
9 MR O'MEARA: Accepting that an approach of that kind has
10 demonstrated this benefit historically, and as you've
11 identified the question is how that is to be approached in
12 a contemporary and modern setting, what do you see as being
13 the issues in imagining crisis teams in a modern setting?
14
15 DR GRIGG: Well, they're probably pretty similar, what's
16 the scope of the crisis team, so what's the balance between
17 assessment and treatment, so what's the options? As Peter
18 says, as demand for these services grew without resources,
19 more and more work went into assessment, much less went
20 into treatment options to keep people at home.
21
22 How do you use them potentially to support people as
23 they leave hospital? So that step-down option, as well as
24 preventing hospitalisation.
25
26 What are the interface issues? So, again, they
27 started getting quite complex design issues when a lot of
28 resources went into Emergency Departments, so you find a
29 lot of people turning up to Emergency Departments. But
30 increasingly, so now we've got - I can never remember the
31 new name for the PACER initiative, but the police and
32 mental health workers do some of that.
33
34 Barwon have been doing a trial around ambulance and
35 kind of mental health workers, and so, you do have to sort
36 of navigate what some of those interface issues might look
37 like, because what you don't want is five different
38 services delivering pretty similar services because that
39 gets pretty inefficient.
40
41 I do think the opportunity to think about what virtual
42 care might look like and how we may much more use
43 technology effectively, and so, for example, I was just
44 talking to one of our own teams about how we might simply
45 use text messaging, you know, in a follow-up for people who
46 have made a suicide attempt. We know the importance of
47 follow-up of the person after they've left the Emergency

1 Department, how effective that is in reducing the
2 likelihood of a future suicide attempt, but that follow-up
3 doesn't always have to be face-to-face; you can find really
4 innovative programs where, for example, people are sending
5 regular text messages: have you done this, have you thought
6 about this, is everything going okay?
7
8 I do think in design there's also the real opportunity
9 to think about the ways in which we use technology in a
10 contemporary space and not always have to rely on it being
11 delivered in a face-to-face type fashion.
12
13 MR O'MEARA: Thank you. Can I go to a topic which was
14 discussed last week about which there was a difference of
15 views, albeit a very good natured one, which was the role
16 of secured extended care units and you expressed some views
17 about that.
18
19 DR GRIGG: Yes. So, I don't think Peter and I completed
20 the conversation because I think many of the references he
21 made was really about work they've done about their own
22 individual secure extended care.
23
24 But if I were to step back and look at them as a
25 system of care, both from my experience in the Department,
26 but also from my experience here, I'd make three
27 observations. One is, there is often excess demand for
28 those services. So, many of the services receive a lot
29 more referrals for people than there are available.
30
31 The second observation I would make probably aligns a
32 little bit to what Peter said in his witness statement;
33 that is, the level of security and their ability in
34 particular to manage quite complex behaviours including
35 occupational violence.
36
37 So, I think at any given time we have three to four
38 admissions of quite - of people being referred to us from
39 the civil system with quite complex behaviours who are
40 unable to be contained in the secure extended care system
41 but for which we don't have capacity, and some of that's
42 really about how we might think about actually what's the
43 design and model of care in those facilities that give rise
44 to its ability to much more effectively manage behaviours
45 of concern, including I think some of the complex issues
46 associated with disability.
47

1 The third issue that I might raise is really the kind
2 of recovery orientation and the level of amenities within
3 them, so the extent to which the services think about kind
4 of containing people and hope that, you know, something
5 happens with their illness to get things better. Because
6 often the environments themselves have really limited
7 interfaces with broader psychosocial environments, so they
8 are frequently sitting on acute hostel campuses where
9 there's very little outdoor space, for example; where the
10 abilities to connect into our communities safely are
11 limited.
12
13 And so, I do think that there are real opportunities
14 as we think about that very small but really important
15 group of people with quite complex needs, many of whom
16 we're seeing really cycle through prisons, you know, or
17 moving between homelessness, in and out of inpatient units;
18 sometimes having done periods in SECUs that the current
19 models of care that we've got for that group of people more
20 broadly I think at the moment aren't really very effective,
21 but less of a comment on Peter's individual SECU service.
22
23 MR O'MEARA: Just before I come to you on that topic,
24 Mr Kelly, I'd like to welcome back Ms Anderson and ask her
25 about the importance of longitudinal care. I opened up
26 this topic by asking Mr Kelly about continuing as opposed
27 to episodic care, but Ms Anderson if you can talk about the
28 importance of care over time or, as you've described it,
29 longitudinal care.
30
31 MS ANDERSON: It's really important. For me it took from
32 acute mental illness to a really stable recovery phase
33 10 years, and in that 10 years I accessed housing and
34 support, psychosocial supports, clinical care, and just
35 self-managing my illness. Part of that was - after my
36 acute episode is to really discern what type of care I
37 needed and what type of care I needed going forward, and
38 part of that was volunteering, getting stable employment;
39 having my peers around me and getting peer support in an
40 informal way, because there was no peer support programs
41 then, and able to access the care I need. It was a
42 really - I was very fortunate to be able to do that.
43
44 MR O'MEARA: You refer in your statement to the experience
45 you had when you first spoke to Neami National and you were
46 asked questions about how you were and that set you on a
47 recovery path, I wonder if you can speak to that because it

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1 seems that from that point the kinds of supports that
2 you've described then became supports that you were able to
3 access and were available to you; I wonder if you can tell
4 the Commission about that.
5
6 MS ANDERSON: Yeah, I was - people only spoke to me about
7 my medication and what I should be doing clinically and not
8 about my life and where it was going and what dreams, what
9 hopes and dreams I had, and so, when I spoke to Neami the
10 question was put to me, "What's happened to you?" It
11 wasn't about my case, it wasn't about medication, it was a
12 personal question about my life and where I wanted to go,
13 and so, the supports I received from them was
14 strengths-based. So, they did exercises with me about what
15 my strengths were, they supported me in being a mother,
16 they supported me in maintaining my housing, they supported
17 me in doing budgeting, all those things took time, it took
18 time to sink in, but it was reinforced time and time again
19 together with my clinical supports.
20
21 So I think it's important it's not one or the other, I
22 think you need both, the clinical support and the
23 psychosocial support together, and it takes a long time. I
24 took up some volunteering, the opportunity was to take up
25 volunteering, which led to employment for me so I was very
26 fortunate.
27
28 MR O'MEARA: We've heard from Dr Grigg that it might be
29 that the emphasis between the clinical support on the one
30 hand, and non-clinical supports of the kind that you've
31 described on the other, might be different at different
32 stages or phases of illness; was that your own experience,
33 that there was an emphasis upon clinical at one point and
34 an emphasis upon the non-clinical at other points and, if
35 so, is there a role in the system for reflecting that
36 emphasis?
37
38 MS ANDERSON: The emphasis on the clinical support was
39 when I was acutely unwell, but other than that, going
40 through my phases of illness and relapse the emphasis was
41 on clinical support. But the psychosocial support came in
42 fairly quickly and they worked hand-in-hand, they worked
43 together, so they worked in tandem, it wasn't one or the
44 other.
45
46 MR O'MEARA: Thank you. Before I move away from you,
47 Ms Anderson, have you got some other observations

1 concerning some of the topics? I'm conscious that you have
2 been on the system at one point and you were off the system
3 at another, and so, I'm not quite sure what you missed, but
4 you might not know what you missed either, so by all means
5 you can ask me, or you can comment upon that which you saw
6 but that I'm not conscious that you saw because I don't
7 know whether you were on the system or not at the time.
8
9 MS ANDERSON: No, I was off the system for quite a few
10 minutes. I'd just like to emphasise the importance of
11 peers in the recovery process, and especially in the in
12 between referring times.
13
14 So, in between, say, in a hospital stay and the time
15 that lapses before being referred to a GP, that you have
16 that personal connection with somebody along the journey.
17
18 MR O'MEARA: And you've got in mind particularly peer
19 workers; is that correct?
20
21 MS ANDERSON: Yes, peer support workers.
22
23 MR O'MEARA: Thank you. I understand that I'm entirely
24 changing the topic a bit here, Mr Kelly, but I'm going back
25 to your experience and observations concerning the SECU in
26 Sunshine in order that you can give the perspective upon
27 the operation of that service. I raised the operation of
28 SECU services in a general sense with Dr Grigg, but I'll
29 allow you to explain to the Commission how the SECU in
30 Sunshine operates.
31
32 MR KELLY: Well, firstly, I'm extraordinarily proud of the
33 work that's done at the SECU at Sunshine. It's been
34 operating for over 20 years. It's a professorial unit,
35 it's headed up by Professor Christos Pantelis who's a world
36 renowned expert in the area of treatment resistant
37 psychosis.
38
39 I think the name is a bit of a misnomer in the sense
40 that they're not really secure, they're probably less
41 secure than our acute inpatient units to be honest.
42
43 The original mandate of the SECUs was to treat people
44 with treatment resistant psychosis. And I mean, this might
45 sound odd, but up until quite recently we've had three
46 consumers at the Sunshine SECU, or the Adult Mental Health
47 Rehabilitation Unit as it's known, that had been there for

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1 over 10 years. So, they certainly had a refractory illness
2 that couldn't be managed in the community and, if we go
3 back 30 years, these are the sort of folks that would have
4 been in long-term institutional care.
5
6 The current length of stay in our SECU is close to
7 9 months, and so, typically consumers who are referred into
8 the SECU have a treatment resistant psychosis but with a
9 whole number of layers of complexity. Often there's a
10 forensic overlay, there's an illicit substance use overlay,
11 there's often an intellectual disability or an autistic
12 spectrum disorder, and there's a myriad of social problems
13 in terms of housing and so on.
14
15 Typically what the team will do is conduct a file
16 review and often times the type of consumers being referred
17 into the service have 15 to 20 volumes of medical records,
18 so they'll go through those records from top to tail and
19 really just try and understand the person's treatment
20 history in a much more detailed and profound way.
21
22 They'll often wash out the medications that the person
23 is on and start afresh, but also conduct a very detailed
24 organic work-up. In other words, they'll try and see if
25 there's an underlying physical cause for the person's
26 mental state, recommence medications and try and stabilise
27 the person's mental illness. And so, typically that
28 process takes about nine months.
29
30 So, throughput is slow and there is simply more
31 referrals than there are beds available. I think it would
32 be a fair comment to say that SECUs are not all of the same
33 standard or run to a consistent model across Victoria, and
34 I'm not being disparaging by that, they're all set up
35 slightly differently, have different levels of
36 infrastructure, et cetera.
37
38 What has emerged in recent times is a push for the
39 SECUs to admit and care for a cohort of consumers referred
40 through the Victorian Fixated Threat Assessment Centre.
41 So, these are people that have radicalised views, that have
42 been caught up in the criminal justice system and a large
43 percentage of these folks that engage in these sort of
44 behaviours have a mental illness either diagnosed or not.
45 So, these are the type of referrals that we are starting to
46 see now on top of the chronic treatment resistant type
47 presentations.

They are certainly recovery phase focused units. We're extraordinarily proud of the work that our staff do in the SECU at Sunshine.

MR O'MEARA: Thank you. Can I move to a different topic and I'm really raising two slightly different things, but one concerns, and you have some experience of this, the role of the private system and the relationship between the public and private systems and the benefits there might be in a relationship with access to the private system, and also moving to the issue I identified right at the outset which is specialisation which you have experienced in your own service, some degrees of specialisation, and the extent to which that can be regional, state-wide, local or other when we're talking about the kinds of streaming services that there might be that were mentioned right at the outset: eating disorders and the like. I wonder if you can speak to those two issues and then I'll move from there to Dr Grigg.

MR KELLY: I suppose in my statement what I referred to was the symbiotic nature of the relationship between the private and the public system. Many psychiatrists who work in the public system also want a mix of private work.

If we go back about 15 years ago, I think, we recognised that there was a real maldistribution of private psychiatrists west of the Maribyrnong River in Melbourne, and so, we set about developing two private consulting suites; one at Harvester Clinic in Sunshine and the other at 130 Bell Street in Coburg. What we wanted to do was provide opportunities for psychiatrists working in the public system to also do private work, and ideally that consumers that we were treating in the public system would migrate through to those private psychiatrists and have a continuity of care in that way, but also building in an easy re-entry back into the system if the private psychiatrist is no longer able to meet the needs of that person; in other words, if they became acutely unwell they could be referred quickly and easily back into the public system, and that model has been very successful.

One, we've retained a lot of private psychiatrists in the public system that otherwise would have moved into full-time private practice and, secondly, we have now got 8,000 consumers registered across those two private

1 practices. Now, I'm not trying to mislead you, that's a
2 mixture of consumers who have migrated from the public
3 system but it's also allowing the private psychiatrists to
4 do the sort of work that they might also feel stimulating
5 and interesting and accords with their subspecialty
6 training, whether it be eating disorders or neuropsychiatry
7 or what have you.
8
9 MR O'MEARA: Thank you. Dr Grigg, if you like, unlocking
10 the potential for the private system on the one hand and
11 access to or links to specialised or streamed services on
12 the other, how can this problem best be approached?
13
14 DR GRIGG: So, I think that's a really important question.
15 The public/private interface in mental health is quite
16 different to the public/private interface in many other
17 areas of health, where the degrees of overlap between the
18 two of them are much greater. And so, while there's good
19 examples such as Peter describes of the work done in
20 NorthWest, largely that's pretty kind of marginal and both
21 systems, both in the context of hospital care in the
22 context of psychiatry, but also increasingly in access to
23 psychological services are operating in silos.
24
25 I think there would be a couple of comments that I'd
26 make here. I think it's important in a system design sense
27 for us to think about what incentives we're putting in
28 place in the public system to better lever it into the
29 private system. Initiatives such as Peter's are good
30 examples. There are public services that have been looking
31 at developing relationships, for example, with private
32 hospitals that both formally, such as Mercy Health, but
33 also informally, St Vincent's has always had a relatively
34 strong relationship with Healthscope.
35
36 So, thinking about those, but I would note that
37 there's a greater opportunity - the Productivity Commission
38 Report is soon to come out. There are at the moment I
39 think really good opportunities for the Federal and State
40 Government to work together. There does need to be
41 a degree of harmonisation at the State and Federal level if
42 we're really to realise as much intersection between the
43 two.
44
45 Probably the other thing I'd say, which I really think
46 is worth having a look at: so, if we think about COVID and
47 I go to a completely different discipline area such as

1 intensive care - Peter's made a couple of references to it.
2
3 So there's always been a capacity for public patients
4 to be admitted in intensive care where there's an absolute
5 capacity overrun but it's been very limited, very marginal.
6
7 COVID saw major shifts in the role of private health
8 services in the delivery of public healthcare, including in
9 the access to both intensive care capacity within the
10 private system and elective surgery, and these came out of
11 unprecedented cooperation between the State and Federal
12 Government to solve a problem in front of them.
13
14 Which says to me - I think this loops back to the
15 innovation of COVID, which is not just on-the-ground
16 innovation of activity - but actually showed that complex
17 kind of policy gaps between various levels of Government
18 are possible to address if there's a will to do so, and it
19 certainly increased my kind of line of sight in the ability
20 to think about in some future state what is a different
21 role of private hospitals, how can we lever in and access
22 much more effectively? I do want to keep private
23 psychology in the loop as well as private psychiatry,
24 that's becoming increasingly important, and there's
25 probably no better time than now for us to be ambitious in
26 our thinking about what that could look like.
27
28 MR O'MEARA: Thank you. Ms Anderson, can I go to you
29 about the importance of specialisation and access to
30 specialty services and also, if you have an experience of
31 it or knowledge of it, private providers.
32
33 MS ANDERSON: Thanks. Specialisation in certain - you can
34 access specialised services if you're in certain catchments
35 and, if you're not in the right catchment at the right
36 time, you're not able to access some of those specialised
37 services. So, I don't know what is the answer is, I think
38 it is with specialised services, that you should be able to
39 cross catchments if there's a specialised service in a
40 different catchment that you need.
41
42 I also think - sorry, what was the second part of the
43 question?
44
45 MR O'MEARA: And access to the private system.
46
47 MS ANDERSON: I'm very lucky I have a private psychiatrist

1 that bulk bills - that's very rare - but without that
2 relationship over the 10 years with that private
3 psychiatrist I don't think I'd be where I am today. So, I
4 think the private hospitals are under-utilised. I think,
5 in agreement with the Federal Government, that there should
6 be some sort of more agreement around the use of private
7 hospitals, and also more Medicare benefits for private
8 psychiatrists to bulk bill.
9
10 MR O'MEARA: Thank you. Mr Kelly, NorthWestern Mental
11 Health has got a partnership with some private hospitals, I
12 wonder if I can ask you to speak to that.
13
14 MR KELLY: Certainly. The Department or the Government
15 has recognised the shortage of beds across the north and
16 west of Melbourne and as an interim strategy has funded us
17 to purchase three beds each at the Melbourne Clinic,
18 Northpark Private Psychiatric Hospital and Wyndham Clinic.
19 So, nine beds in total we can access.
20
21 I started off this morning by talking about the 31
22 patients in the Emergency Department; yet out of those nine
23 beds we've only got eight occupied at the moment. So,
24 there is a threshold issue around risk that the privates
25 are able to admit up to and then not beyond.
26
27 So it's sort of an interesting comment, isn't it, that
28 we talk about sometimes that hospitalisation is not
29 required, yet I've got people queued up in Emergency
30 Departments and yet they're all too risky to go into a
31 private bed at one of those hospitals.
32
33 The other comment I'd make about the privates is that
34 their model of care typically in these arrangements with us
35 is for a 28 day admission against our nine day average at
36 NorthWestern Mental Health. Now, you could ask yourself,
37 well, why is that so? Why 28 days and not 21 days or 14
38 days? And it's probably linked to the sort of caps on what
39 the funds will pay out. So, in other words, at the end of
40 28 days the person is discharged back into the primary care
41 sector.
42
43 We have sought to try and drive down those lengths of
44 stay to get them more commensurate with ours, but on the
45 other hand you can say, well, actually that's the perfect
46 length of stay for someone with an acute mental illness and
47 they'll do everything that's required in that 28 days and

1 that's perfect. We can't match it though.
2
3 MR O'MEARA: Thank you. Going back to you, Dr Grigg, you
4 introduced or referred to the issue of virtual resources
5 and virtual care; can I ask you to introduce that topic on
6 a broader setting. What do you see as the role for virtual
7 care in the different phases of the system, if you like,
8 potentially?
9
10 DR GRIGG: Look, I think that there is a - so, firstly, is
11 to say, there are very, very limited contexts in which I
12 think virtual care replaces face-to-face care. But
13 nevertheless as an adjunct into the system we are seeing
14 enormous innovations in the use of a range of technologies,
15 both in terms of triage, accessing treatment, creating
16 communities, communities of interest. SANE Australia, for
17 example, is doing some great work around a virtual
18 environment really creating a place where people with
19 senses of shared experience can come together.
20
21 If we look at the amazing work that's being done by
22 Headspace in their treatment models, but we can even get
23 very, very innovative and look at some of the hospitals in
24 the US who are now using avatars as part of their suicide
25 assessment process. So, when people turn up to an
26 Emergency Department in a couple of the EDs they actually
27 can have an avatar to do your suicide assessment instead of
28 seeing a face-to-face clinician. And we need to recognise
29 the way one might think about the way Ambulance Victoria is
30 using virtual reality as a training tool for its staff in
31 better managing occupational violence.
32
33 I think that there is a big space for us to be
34 thinking about the ways in which in mental healthcare the
35 technology in its broader sense provides us with real
36 opportunities to supplement and adjust our models of care
37 so that they're able to be much more personalised and
38 person-dependent, which is probably a different view
39 because it's balanced over here with they're kind of cheap,
40 and they take people away from the interaction and they
41 increase the sense of loneliness and disconnection from the
42 world. The reality is both those experiences are the same
43 nevertheless. I think it's going to be a really important
44 place for us to think about.
45
46 MR O'MEARA: Thank you. So, far this morning all of you
47 have given some evidence about the bed-based system and

1 experiences both here and in New Zealand and other places
2 concerning that; Dr Grigg's just talked about virtual
3 possibilities and there's been reference to CAT teams,
4 there's been reference to other elements of the system such
5 as private sector, and we'll come to the issue of moving or
6 navigation between the various elements shortly, but one of
7 the areas that we haven't yet discussed which each of you
8 discuss in your statements is the community-based mental
9 health system or for that matter what have been described
10 in some of the statements as hubs.
11
12 Ms Anderson, you've described them in your statement
13 particularly as psychopolises, so if you can talk about
14 that.
15
16 MS ANDERSON: Yes, psychopolis to me is a term that
17 denotes that all mental health services are in one place
18 and only mental health patients go to that mental health
19 service, and it just becomes like a psychopolis, so a mini
20 institution.
21
22 I think community-based care should be open to the
23 community, whether it's with mental health, physical
24 illness or whatever; it shouldn't just be based on a mental
25 health diagnosis, it should be based on community care for
26 the whole community.
27
28 MR O'MEARA: Thank you. Do you have any other
29 observations concerning that model of care and benefits in
30 it?
31
32 MS ANDERSON: I think the benefits of hubs is around
33 community care, where you can go in and you can have the
34 dietician talk to your mental health clinician, or the
35 diabetes educator talk to your mental health clinician; I
36 think that's a benefit, I think the holistic care that you
37 could receive at a community hub would be really beneficial
38 so you don't have to tell your story over and over again
39 and go to 20 different appointments at 20 different
40 locations.
41
42 But I think we have to be careful that it's not
43 stigmatised just for people with mental health issues and
44 it's open to the whole community.
45
46 MR O'MEARA: Thank you. Mr Kelly, you've referred in your
47 statement to the way in which such a hub might work and

1 you've made reference to the - it's not called a hub, but
2 it is nonetheless of this kind of style of service in
3 Melton, and I wonder if you can start by identifying the
4 kinds of services that are available there, how it's been
5 operating, and the issue of thresholds gaining access to
6 that service.
7
8 MR KELLY: Well firstly I agree with Julie, I don't think
9 it's necessarily helpful to have a mental health hub per se
10 but to have mental health services located within a hub
11 with lots of other services that can assist people that
12 require them.
13
14 We've over the last nine months or so located a
15 service out at Melton, so it's the outer team from Mid West
16 Area Mental Health Service, it's located in the Djerriwarrh
17 Health Service Community Services hub there, and there are
18 a myriad of services co-located. So, Djerriwarrh Health
19 Service where they've got dietetics, podiatry, dentistry
20 services, there's a social housing agency located there as
21 well. There's a community justice centre.
22
23 So I think the intention is to build up these sort of
24 services so that people can effectively be easily linked
25 and referred and easily access services such as community
26 housing, Centrelink, all of those services that people
27 struggle to navigate their way through.
28
29 It's a helpful and useful model, it's palatable to
30 consumers, but of course the big question arises, well,
31 what is the threshold for entry and receipt of services?
32 And, as we've all been discussing, the threshold just
33 continues to rise in a sense and so at some point you'd
34 have to think that services would be means tested or
35 otherwise rationed because they can become too palatable,
36 too accessible.
37
38 MR O'MEARA: Is it presently the case that the service is
39 rationed in Melton?
40
41 MR KELLY: Our service is rationed, absolutely.
42
43 MR O'MEARA: What does one need to - what's the
44 qualification for gaining access to the Melton service?
45
46 MR KELLY: The mental health service?
47

1 MR O'MEARA: Yeah.
2
3 MR KELLY: Well, it's a level of risk and disability I
4 guess. So, have a serious enduring mental illness, a level
5 of risk and a level of disability are the hurdles that have
6 to be crossed.
7
8 MR O'MEARA: You've referred to other potential
9 qualifiers, if you like. Let's take as an example pension
10 card, what are the benefits or disadvantages in
11 particular - and you've identified the one which is
12 actually being implemented which is, if you like, a degree
13 of acuity; what are the benefits or otherwise of
14 approaching thresholds in these various ways?
15
16 MR KELLY: Well, it's interesting in the context of
17 COVID-19, you may be aware that Associate Professor Ruth
18 Vine has been appointed as the Chief Mental Health Officer
19 for the Commonwealth; that's come on the back of modelling
20 from the Commonwealth Department of Health that shows that
21 more people will die by suicide as a consequence of
22 COVID-19 than will die from the pandemic itself, and we're
23 starting to see some of this need presenting in our
24 community clinics and indeed in our inpatient units and
25 Emergency Departments right now.
26
27 For instance, the family in Melton that had both
28 partners working, they've now both lost their jobs, their
29 accommodation's under threat, they won't be pension
30 cardholders but they will be struggling, and so, I think
31 having arbitrary sort of measures like pension card or
32 means testing will disadvantage many people that are caught
33 up in this profound and rapid social change that's
34 occurring now as a consequence of the economic downturn.
35
36 MR O'MEARA: Thank you. Dr Grigg, you've made some
37 observations concerning the benefits of hubs and the kinds
38 of disciplines that might best be available in that kind of
39 setting, I wonder if I can ask you to speak to that model.
40
41 DR GRIGG: You know, I think that I said it depends what
42 we mean by a hub, some sort of geographical presence. I
43 would share Peter and Julie's concerns about just
44 identifying something for mental health, while also
45 noticing in a broad sense that a platform such as headspace
46 has actually been destigmatising rather than stigmatising.
47

1 You know, I was struck when my own nieces and nephews,
2 you know, who wouldn't talk about anything to do with
3 mental health but would turn up for headspace because it
4 was seen as a non-stigmatised place to go, so we should
5 also think about these from the context of stigma and from
6 our opportunities to reduce stigma rather than increase it.
7
8 Fundamentally though, in the context of having a
9 geographical place where there's an identity for people to
10 go, those functions of triage processes and entry and how
11 you set thresholds. I have to say again, I think that
12 there's both been demand elements in mental health; I think
13 there's cultural elements in mental health in terms of the
14 hoops that we sometimes ask people to go through before we
15 look at them accessing mental health services, and that
16 sometimes those hoops are really designed to exclude people
17 rather than ask the question of, what have we got here that
18 might help you, which I think is an important cultural
19 element of how we go about working with, kind of, triage
20 systems.
21
22 I think the issue of co-location of services for ease
23 of access is really important, and if you design hubs
24 around models of care that create integration and pathways
25 between them rather than silos of services, then that's
26 extremely helpful for people getting a broader range of
27 services, but it needs to be connected to the system
28 navigation issue, because you can't imagine the hub that
29 has everything, that has everything that every person with
30 a mental health problem could possibly want coming into
31 that place, and even if I were to call that place something
32 like The Alfred Hospital, even then it doesn't have
33 everything.
34
35 So it's actually also about what we put together, how
36 we create navigation, and I think the issues of the
37 navigation about how we also think about virtual hubs.
38 There has been various initiatives over time and they kind
39 of wax and wane about the ways in which you bring local
40 services together to actually create cooperative pathways.
41
42 Also often if you go into rural communities you'll see
43 these as very living and natural ways of operating, in ways
44 we can't kind of manage in the city because in communities
45 where just people know each other in different ways and
46 where often there is way less resources than we have
47 sitting in city areas, they've often found really, really

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1 creative ways of actually fostering navigation and
2 cooperation in a very real and important role for local
3 governments in actually being the knitting together of
4 those quite localised services that people may want to use.
5
6 MR O'MEARA: Just before I go to Ms Anderson on this
7 topic, does it follow from what you've said, Dr Grigg, that
8 it might be that a service of that kind can look very
9 differently in the city to how it might look in a rural
10 setting?
11
12 DR GRIGG: Yes, and I would expect it should, and in fact
13 I might go - it might look different in western Melbourne
14 than what it looks like in the inner east of Melbourne as
15 well, because there are actually really different kind of
16 service systems, relationships between kind of providers.
17 But I will say probably one of the unifying elements that I
18 think it's worth thinking about is the potential role that
19 the local government can play and the leadership role that
20 local government can play in really place-based local
21 responses to driving and supporting connections between
22 services that helps them facilitate the navigation system.
23
24 MR O'MEARA: Just before we come to that, and I'll be
25 asking Ms Anderson about that in just a moment, would there
26 nonetheless be some degree of essential componentry in a
27 hub or community-based mental health service of that kind?
28 It wouldn't be that, for example, there'd be no
29 psychiatrist in some services and there would be in others,
30 or is that what you're saying?
31
32 DR GRIGG: So, I think you're right, I think that there
33 are some critical elements that you go, you know, there
34 does need to be kind of access to mental health treatment.
35 Potentially they should all have access to substance abuse
36 treatment given the prevalence of substance use disorders.
37 You might want to say, or given the complexity around
38 housing, housing pathways are really important, and whether
39 you use some sort of in-reach model from your housing
40 providers or something might equally kind of want to
41 prioritise employment - I'm doing this list without a lot
42 of thinking.
43
44 So, I do think it's possible to go kind of, here's
45 five or six core elements and different ones might have
46 others; physical health is probably another one of those
47 core elements, at least at some level of primary care of

1 them - I knew I could think of extra elements if I thought
2 about it.
3
4 And in a practical sense the other initiative that I
5 would at least encourage the Royal Commission to have a
6 look at is the current Government's commitment towards the
7 development of community hospitals. So, there is an
8 existing commitment for community hospitals as an
9 initiative particularly in some of the growth corridor
10 areas, and they are still in relatively early period of
11 design, but one could - another way of thinking about these
12 facilities might actually be as very big hub facilities,
13 building on models such as Melton, that is a really good
14 opportunity for - you know, again in that way that I - it's
15 very important in finding solutions that as much as
16 possible would leverage what exists. It might be kind of a
17 really good kind of platform to be thinking about, so what
18 in a design sense might mental health look like in those?
19
20 I'm no longer close enough to those designs to know if
21 that question's actually been asked, but I think it's an
22 interesting initiative that is already sitting in the
23 system that I think has got some of the aspirations for the
24 broader health system that share aspirations into the
25 mental health system.
26
27 MR O'MEARA: Thank you. Ms Anderson, can I go to you
28 about the role or the importance of access to physical
29 health in a setting of that kind?
30
31 MS ANDERSON: It's really important physical health,
32 including dental; a lot of consumers don't have good dental
33 hygiene, and so, diabetes is a problem, obesity is a
34 problem. Life expectancy of people with mental illness is
35 a lot lower than the average life expectancy of people, and
36 so, access to physical health services is vital along with
37 mental health and those systems should be talking to each
38 other; it's not one or - that the mental health teams
39 should be talking to people around a person's physical
40 health. Make connections with a GP, a dietician, a
41 diabetes educator, a sports physiologist, as well as peer
42 support workers.
43
44 MR O'MEARA: Thank you. Just going back to you, Dr Grigg,
45 you raised the topic of, in a sense - and I'm saying this
46 in a colloquial way, but who runs these things? You've
47 referred to the example of, if you like, a community

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1 hospital being run by a hospital and that that might be a
2 platform for either access to or also including a
3 community-based mental health hub, if you like: does it
4 necessarily follow that such a thing would be best run by a
5 hospital and therefore integrated with the hospital system,
6 or is there a better way or other ways of approaching this?
7
8 DR GRIGG: Firstly I'll say there's a whole range of
9 governance questions around those as is, and so, it may
10 very well be a hospital who owns the infrastructure, where
11 they may not necessarily run what's within that
12 infrastructure because around - there's a really strong
13 understanding around the issues of chronic disease
14 management, that these community hospitals is part of their
15 mandate. Again, in a similar way the role of what
16 psychosocial factors play and the desire to actually make
17 sure that there's a strong psychosocial focus within that
18 so we don't mean that.
19
20 But it is a wicked question, the question of
21 governance, and I feel like 20 years ago if you had asked
22 me this question I would be unmoving on the role of health
23 services and in the importance of mainstreaming in actually
24 the delivery of mental health care.
25
26 Twenty years on, and with lots of experiences of some
27 of the limitations of mainstreaming, what is a much more
28 complex - a complex environment for service delivery, I do
29 wonder a little bit more about the opportunity to think
30 about layered and scaled governance options and the ways in
31 which partnership is seeded in more structured ways so that
32 there are stronger levers and directions of Government for
33 agencies to join up and connect there.
34
35 And to give again a tiny example, I think, of some of
36 the innovation around this that Victoria is experimenting
37 with at the moment is the idea of creating hospital
38 clusters. Firstly, this has been done as part of the COVID
39 response: how do you make your intensive care system work?
40 Well, what they did was ask our group hospitals: public,
41 private, community and with PHNs, we work together in a
42 joined up way to actually deliver a kind of an integrated
43 plan, which in the cluster we're part of managed to do that
44 in less than four weeks of - I've just been reading it -
45 managed to produce actually a 100-page plan that had a
46 whole range of levels of cooperation that I'd have not
47 really believed was possible.

1
2 So, I do think that increasingly we will need to
3 answer the governance question at multiple levels, and that
4 we should open up the question of governance potentially to
5 more flexible options; it may not be a one-size-fits-all
6 but needs - I quite like and I wrote down at the beginning
7 of thinking about what's local, what's regional, what's
8 state-wide, because that needs a fitness for purpose for
9 scale, but it is actually about how we make those
10 boundaries between our governance agencies both a little
11 bit more permeable and more accountable so that the
12 connections between them work.
13
14 I realise that's a pretty kind of rambling statement
15 that sort of goes from, I no longer think there's a single
16 simple answer to the question of governance.
17
18 MR O'MEARA: Mr Kelly, what do you think about - this
19 started off with who runs the community-based mental health
20 services and then metamorphosised into - which is a very
21 big word for the purposes of today - but metamorphosised
22 into how the whole system runs.
23
24 Your service has got all kinds of specialities, it's
25 linked with community-based mental health service in Melton
26 and it's got other things as well; I wonder if you can
27 speak to the issue of governance that Dr Grigg has
28 introduced.
29
30 MR KELLY: Yeah. I would answer the question about, which
31 is the best entity to provide that care, by asking
32 rhetorically, which entity would deliver the best outcomes
33 for people with serious mental illness.
34
35 I can tell you that, about a decade ago I started to
36 notice some alarming data coming across my desk around the
37 age that consumers in our service were dying of natural
38 causes, so I started maintaining a database. I've got 170
39 names on that database now and I can tell you that the
40 average age of death for a consumer in our service that
41 dies of natural causes is 45.7 years, if you look at that
42 whole database. But if you look at the three commonest
43 causes of death which is cardiovascular disease,
44 respiratory disease and cancers of all types, then it's
45 50.1 years.
46
47 The Australian Catholic University have just used this

1 data to write an academic paper that's about to be
2 published shortly, but Julie mentioned before that people
3 with a serious mental illness have reduced life expectancy:
4 well, according to my numbers it's 30 years less life
5 expectancy.
6
7 If I just give you the ages of the first 10 people on
8 that list, they're alarming and frightening: 44, 49, 42,
9 46, 58, 57, 45, 49, 48 and 28. You don't see these sort of
10 numbers in the general community, so there's something
11 about the access to healthcare that impacts in a very
12 profound way on people with a severe and enduring mental
13 illness.
14
15 And what's alarming in that 170 names on my list is
16 the number of deaths that are recorded after an autopsy and
17 after a toxicology screen as unascertained or undetermined.
18 That's unusual. My previous Executive Director here,
19 Professor Ruth Vine, took that up with her opposite number
20 at the Victorian Institute of Forensic Medicine and he felt
21 that, if you looked at a similar cohort that died suddenly
22 and unexpectedly in the general community, you would not
23 expect to see those sort of numbers of undetermined and
24 unascertained deaths.
25
26 So, people with a serious and enduring mental illness
27 cop a raw deal, I think, in the general acute system,
28 there's no doubt in my mind about that, and they're
29 alarming numbers and alarming figures about life
30 expectancy. These are often about cancers being diagnosed
31 too late, too late to treat effectively; about people
32 presenting too late in the episode of illness for effective
33 treatment to be provided.
34
35 I do think it's probably likely that people do receive
36 a level of discrimination in the general acute system if
37 they're seriously mentally ill, and they're just awful
38 numbers related to, you know, cigarette smoking, alcohol
39 use, sedentary lifestyle, and I guess to some extent the
40 negative symptoms that come with schizophrenia that leave
41 people, sort of, amotivated and with a lack of initiative
42 and drive to do all the things that we do to try and
43 maintain our health.
44
45 MR O'MEARA: Thank you. I'm conscious that with my
46 enthusiasm for today's topic that I've managed to overlook
47 the obligatory break that we have in the middle of these

1 panels and I'm not going to have this break every time we
2 have a panel, but I'd prefer to have it earlier, but why
3 don't we have it now. Ordinarily for comfort purposes we
4 would have one, and we can have a break of say five minutes
5 and come back and then deal with the question which was
6 raised right at the outset in the opening remarks and has
7 been touched on in various different ways in the course of
8 the panel so far, which is the question of catchment areas
9 and in doing that I'll start with Ms Anderson. But at the
10 moment, let's take five minutes.
11
12 **SHORT ADJOURNMENT**
13
14 THE CHAIR: Yes, I think we're ready to go, Stephen, in
15 the interests of time.
16
17 MR O'MEARA: Thank you. I introduced, Ms Anderson, the
18 topic of catchments before we broke. You've expressed some
19 views about the benefits in catchments being based in some
20 way upon local government areas, I wonder if I can ask you
21 to commence that topic by referring to your views on that
22 issue.
23
24 MS ANDERSON: I think catchments should follow local
25 government areas and I think that's because there's more
26 community accountability through local government, and I
27 think the community should take on some more accountability
28 for mental health issues.
29
30 MR O'MEARA: Is that from your own experience, that you've
31 seen the benefits of, if you like, local governance?
32
33 MS ANDERSON: I have seen the benefits of local governance
34 and that includes consumers in that governance. I think
35 it's hard for consumers to understand what governance is,
36 both clinical and organisational governance, and I think
37 that there needs to be more effort to include consumers on
38 governance structures.
39
40 MR O'MEARA: Thank you. Dr Grigg, it looks like you're
41 muted at the moment but by the time I finish speaking you
42 won't be. The alternative view is governance on a broader
43 scale and by reference to catchments that are at the moment
44 hard catchment boundaries or are not hard catchment
45 boundaries. What are the competing views as you see them
46 and what's the preferable view as you see it?
47

1 DR GRIGG: It may be that there are multiple governance
2 options and multiple levels of governance. I'd agree with
3 Julie, I think local government has an opportunity to play
4 an important role and we as a system may not have levered
5 it as effectively as we can.
6
7 Simultaneously, if we step right up and talk about PHN
8 catchments, that may be incredibly useful for the purposes
9 of planning. We've then got how governance operates in
10 terms of organisational structures, which is yet another
11 lens into the concept of catchments, we've got what does
12 that lens mean for patient choice, how does that framework
13 protect vulnerable consumers to make sure they're able to
14 get access to services.
15
16 And so then probably the last element is how do we
17 actually construct governance. I'd really just speak to
18 delivering both, how do we have a governance structure that
19 connects organisations together to deliver integrated
20 outcomes? Because many of the - we step back into
21 recovery, there probably isn't one organisation that's able
22 to do everything that a person needs or wants or prefers,
23 and the issue is how in a governance sense do we ensure
24 that organisations work together to deliver the outcomes
25 that matter for our consumers.
26
27 I think that's the difficult question when you have
28 the kind of catchment question, because typically we see it
29 in a one dimensional way with, you know, as I said earlier,
30 I increasingly see it in a much more kind of multi-faceted
31 way.
32
33 MR O'MEARA: And accepting --
34
35 DR GRIGG: (Inaudible).
36
37 MR O'MEARA: And accepting that it's important for the
38 elements of a system to work together and that governance
39 has got an important part to play, what in your view is the
40 best way of facilitating that?
41
42 DR GRIGG: So, I do think that it's a system design. So,
43 if I could get really kind of concrete, for example, it's a
44 question that I am asking very actively here at Thomas
45 Embling. And if I think about the issue of people leaving
46 prison and really needing to be connected up to care: well,
47 the truth is at the moment the system, you know, the

1 governance ends for us when they leave prison; the
2 governance doesn't begin till an area mental health service
3 or somebody else has happened to accept them into care, and
4 we have this dead space where actually the person is
5 nowhere.
6
7 One of the things I might think about as an
8 organisation is ask the question of: well, why wouldn't
9 somebody hold us as an organisation more accountable for
10 the person to actually then be connected in and stabilised
11 into that system? So, not even just that point of a flat
12 referral but, for example, there might be a KPI that tells
13 me what proportion of people that we've been working with
14 who leave prison have actually not only been accepted into
15 a service, but has been seen by that service at least three
16 times - I made up that KPI - overlapping KPIs that provide
17 levers in governance and to connect in, and begin to hold
18 us jointly responsible for how care is delivered.
19
20 Because whichever way you design catchments what we're
21 going to do is, you have chasms between whatever boundaries
22 we join, and good governance or good accountability at
23 various levels to be watching those joining places as much
24 as they are watching what's happening within them.
25
26 MR O'MEARA: Thank you. Mr Kelly, do you agree that one
27 way of overcoming a fixation, if you like, with catchments
28 is to have a good governance approach to what operates
29 within and between the catchment areas?
30
31 MR KELLY: Yeah, that's one approach. I suppose my
32 question is, what problem are you trying to fix by
33 abolishing or changing catchments? I mean, if we go right
34 back to the 1980s again, prior to the
35 de-institutionalisation process, we had the Office of
36 Psychiatric Services, so it was set up as a separate
37 Department, the mental health system, within the Department
38 of Health and Human Services. Mainstreaming occurred
39 because the big institutions closed down and they wanted to
40 provide better access to physical healthcare and drag the
41 mental health system out of the shadows and into the
42 mainstream. Has that been an overwhelming success? Well,
43 it's succeeded in many ways, but in other ways it probably
44 hasn't, given the conversation we just had about mortality
45 data.
46
47 So, there are a number of ways to organise it. The

question is, should they be - the catchments - the way they are? What's the purpose of a catchment? It's designed for population-based planning, I think, but I think largely the problem is that the planning hasn't kept pace with the population growth and that's led to serious inequities across the system.

In my experience, these discussions are often tied up with consumer choice about which service a consumer can access. I fully support freedom of choice, I think most people will actually choose to go to a service that's convenient to where they live or convenient to where they work. So, I think that's absolutely manageable, the freedom of choice in the current system, but the catchments arrangements as they are at the moment are really historically based models that have not kept pace with population growth.

MR O'MEARA: Can I raise one last issue prior to handing over to the Commissioners because I'm conscious that their time is valuable, so to raise one final issue with you, Mr Kelly, concerning the issue of funding, block funding as opposed to, if you like, other forms of funding, activity-based funding, and the focus upon outputs which you've got a particular view upon. If I could start with you on that issue.

MR KELLY: Well, at the moment services are block funded; in other words, they receive a quanta of funding to provide a range of services without a close accounting of the outputs that come with that, apart from recording of service hours.

The Department and the Government have flagged that the Victorian mental health system will move to an activity-based funding system, and in fact I sit on the expert reference group of that Committee. It was planned that the activity-based funding would be shadowed in the new financial year with the block funding model and then implemented the following year, but that's been pushed back I think by 12 months because of COVID-19.

So, moving to a system whereby services are funded by what they do rather than what they'll say they do, I think, will be a positive thing because then you can start to exercise the levers about what elements of the service provision do you want provided for each type of patient

1 cohort, for instance.
2
3 MR O'MEARA: Thank you. Dr Grigg, do you have similar
4 views or not about the benefits of moving to a different
5 funding model?
6
7 DR GRIGG: There is absolutely no doubt that there is an
8 urgent need for funding reform in the mental health sector.
9 It is technically difficult, there's been a lot of work
10 done in the activity-based funding model. I think the work
11 the Department's doing at the moment is very good, it's
12 probably close to some sort of bundling of care, but it is
13 quite technically challenging.
14
15 I think the other thing to keep an eye on is that
16 largely these funding models are really about allocative
17 efficiency; they're really about, how do you decide which
18 health service gets the $5. I used to have accountability
19 for this across the broader health system and I used to
20 really say, "The funding model is only so I can be equally
21 unfair to everybody."
22
23 MR O'MEARA: Thank you. Ms Anderson, can I ask you on
24 this topic about the importance of really funding to
25 facilitate outcomes, and that, outcomes of course are very
26 personal outcomes as you've spoken of this morning; would
27 you be able to give the Commissioners your views about the
28 importance of approaching funding with that kind of focus?
29
30 MS ANDERSON: Yeah, I think it's good to achieve outcomes,
31 but I think the funding, I should have a choice in the
32 funding of what health service I need - what I want from a
33 health service, so I think that choice, that consumer
34 choice about how the funding is spent is vital.
35
36 I also think that in the whole system it's not
37 either/or, I think you need to have choices around what you
38 access. For example, this pandemic has given me a choice
39 to have phone consultations with my GP and that's been
40 marvellous because I work and I've got other commitments
41 and I never had that choice before.
42
43 Now, another person's choice might be actually to go
44 out to go to a hub because they don't have many
45 interactions in their life; it actually gets them out of
46 the house, they talk to the receptionist, they actually go
47 and talk to some people, so I think multiple strategies

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1 around consumer choice is what we should be thinking about.
2
3 MR O'MEARA: Thank you. I am really offering this
4 opportunity to any member of the panel who might wish to
5 say something on any particular topic that we've covered so
6 far before I then allow the Chair to call upon the
7 Commissioners to address questions to you. Don't feel
8 constrained that, if something's been overlooked,
9 Ms Anderson, Mr Kelly, Dr Grigg, if anyone feels they
10 haven't had the opportunity to say something on an issue of
11 importance, by all means take that opportunity now because
12 it's extraordinarily valuable for the purposes of the
13 Commission.
14
15 MR KELLY: The obvious thing for me is that geography and
16 demography are two big issues to consider when
17 conceptualising the size of catchments and how they're
18 sourced. I mean, things like employment levels, workforce
19 skill levels, mean household income, English proficiency,
20 levels of home ownership, there's a whole myriad of social
21 determinants that impact on mental health or mental illness
22 and that's not equal across Metropolitan Melbourne or
23 indeed across Victoria.
24
25 It's a much bigger and more complex issue than just
26 thinking, well, there's a catchment comprised of 300,000
27 people or 400,000 or 500,000, how does that align to a
28 large metro public health service and what other alignments
29 are there across primary health, police districts, local
30 government areas, for instance.
31
32 So it is a complex issue which I'm sure anyone in the
33 health system has grappled with over the last 10 or
34 15 years, because it has come up repeatedly, but there are
35 no easy solutions to this in my mind except to introduce
36 choice and allow people to migrate freely and access to
37 services where they would like to receive them.
38
39 MR O'MEARA: Thank you. At the risk of sounding like an
40 auctioneer, anyone else? Thank you, everyone. Chair, if I
41 can now allow the Commissioners to take the stage.
42
43 THE CHAIR: Thank you very much, Mr O'Meara. Thank you
44 all panel members for your contributions. There are many,
45 many questions I'm sure we could all ask but in the
46 interests of time I'll just start with two issues I want to
47 address and then I'll hand over to my fellow Commissioners.

The first issue goes to the concerns about the current quality of inpatient care. Dr Grigg, in your statement you make the point that:

> *... the combined impacts of very short lengths of stay, heterogeneity of patient's needs, high levels of interpersonal violence and funding constraints have undermined the therapeutic nature of acute inpatient care.*

I must say, the Commissioners have been deeply disturbed by some of the material before us about the lack of safety in inpatient units and the non-therapeutic nature of some of the care that is provided.

Can you comment on whether it is in the interests of safety for all that we should consider streaming consumers to selected facilities not by diagnosis as Julie has warned us about, but by behaviours? So, can I ask any of the panel members to comment on that?

DR GRIGG: I'm happy to comment first, Penny. I think two areas of streaming I am very enthusiastic about: the first is the streaming by gender and providing more choices to women.

The second area of streaming I would be - I think it's very important sitting around some of those behaviours of concern, understanding though when you cluster those behaviours together you have to really think very carefully about your model of care, your elements of security and safety and how you go about managing it.

But I would share some of the horrors and anxieties that the Commission have around the mixing and the experience of some people on acute inpatient units.

THE CHAIR: Mr Kelly, did you want to add something on that?

MR KELLY: Look, they're very difficult and challenging environments. I can give you an example, that about three or four years ago we did a study at Sunshine acute unit where we saliva drug tested every consumer admitted to the intensive care area part of the ward over a three month

1 period, and 80 per cent of those tested positive for
2 amphetamines. So, mixing people with an amphetamine
3 psychosis, mostly males I've got to say, aggressive,
4 driven, behaviourally disturbed males that were floridly
5 psychotic with depressed vulnerable female consumers in a
6 cramped space is completely unhelpful.
7
8 So, if you were designing a service from the ground up
9 you wouldn't design it the way that Sunshine acute unit is
10 designed. It's a 30-year-old model, frankly, with a 20 bed
11 low dependency unit and a nine bed intensive care area.
12
13 And Margaret's comments are right on the money: mixing
14 some of these very diverse groups with different levels of
15 aggression or predatory behaviours at times, amongst other
16 people with different levels of vulnerability, is
17 completely unhelpful. And this is the challenge.
18
19 As I said at the start, we are trying to find beds for
20 31 consumers today in an already pressured environment
21 where the average length of stay is nine days; not 28 days,
22 nine days.
23
24 THE CHAIR: In relation to that, it may well be that
25 there's more limited consumer choice when it comes to some
26 of those alternatives that might make sure we have better
27 control over safety for all, both consumers and staff and
28 those who are also involved in those facilities.
29
30 MR KELLY: Sorry, Commissioner, I'm glad you mentioned
31 that: safety is critical for consumers around sexual
32 safety, and this is what I was alluding to in my opening
33 comment before, but also in terms of occupational violence
34 for clinical staff. It is at horrendous levels, I've got
35 to tell you.
36
37 THE CHAIR: Thank you. Can I then go to my next issue
38 which, we've talked about the importance of
39 self-management, and both Ms Anderson and you, Dr Grigg, in
40 your statement talk about this. I was very interested in
41 the model that you talked about, Dr Grigg, in your
42 statement in terms of the recovery college at Mind
43 Australia, where you talked about the fact that this is a
44 model that works well and extensively in the UK focused on
45 using education principles to assess people to develop the
46 self-management skills required to manage their own mental
47 illness, peer developed and co-designed and peer educated.

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1
2 Can both you and Ms Anderson make comment on the
3 relevance of that sort of model in our future service
4 system.
5
6 DR GRIGG: I'll go first and then hear Julie's. I would
7 love, I would love, to see a model such as the recovery
8 college in the future design. It was, when I first visited
9 a recovery college in the UK, it was one of those ah-ha
10 moments for me, but also the experience of establishing it
11 in Mind Australia what I learnt about in the context of
12 what really mattered to people.
13
14 To give a little bit of an example: we were wanting to
15 run a unit in medication management. And look, it wasn't
16 the usual psychoeducation stuff; when we came back and
17 asked people about what was important, you know, they
18 talked about having the skills to talk with their doctor
19 about how they might reduce or change their medication;
20 they talked about having the skills to assert the
21 medication for themselves; they were much less interested
22 in the technical details and what that medication meant to
23 them in their lives.
24
25 Pretty similarly, I did one of the courses which was
26 on the development of advanced statement and that was run
27 by a woman who was two weeks out of an acute inpatient unit
28 talking in very practical ways of how important an advanced
29 statement was to her and the way in which it had changed
30 her experience as an involuntary admission to an inpatient
31 unit. So I have to say, as a model of care, it was
32 somewhat inspirational to me in thinking about how we could
33 do things differently.
34
35 THE CHAIR: Thank you. Ms Anderson, do you want to add
36 some points?
37
38 MS ANDERSON: I am really impressed with recovery colleges
39 and how the model is set up in the UK. I think, on various
40 levels that, people can come together and connect around
41 common issues and learn some psychoeducation. To be given
42 the tools they need in terms of their own recovery journey
43 and to experience that with other peers, I think, is quite
44 powerful.
45
46 THE CHAIR: We may well follow that up further in terms of
47 an idea. So, can I hand over now to Dr Cockram and then

1 I'll go to Professor McSherry and Professor Fels. So,
2 Dr Cockram.
3
4 COMMISSIONER COCKRAM: Thank you. My question initially
5 is to Mr Kelly. I wanted to come back to the topic around
6 private beds. And, if I put to you the hope, I am sure
7 that many Victorians have, that in a reconfigured system
8 the length of stay in the inpatient units can go back to a
9 more adequate level, that the gap between inpatient care,
10 community and the PARCs repositions those other aspects to
11 be able to deliver the kind of care people would hope, and
12 an inpatient setting becomes again able to provide both
13 streaming and multidisciplinary care again in the way that
14 many have asked for. In that context, where does the
15 public and private model sit, and will it be able to
16 provide a substituted model for public mental health care,
17 or is it some alternative model that we should consider?
18
19 MR KELLY: I think it could, but I think we've got a wee
20 way to go before we can close that gap between the level of
21 acuity that's managed in the public system and the level of
22 acuity, for lack of a better word, that can be managed in
23 the private system.
24
25 COMMISSIONER COCKRAM: So, what would that model offer, do
26 you think, the private model in that hopefully improved
27 public system?
28
29 MR KELLY: Ideally you'd love to have a continuity of care
30 for those folks who are being cared for in private
31 psychiatry, that they can move pretty seamlessly between
32 the public and private system depending on their needs.
33
34 At the moment a person's level of unwellness or acuity
35 has to meet a threshold where involuntary treatment is
36 required before that person would be required to be
37 transferred to a public mental health facility.
38
39 So, I think there could be a much more seamless and
40 complementary arrangement between the public and private
41 system, much like we've striven to do through the private
42 consulting suites; in regard to community care, I think you
43 could extend that to do it quite cleverly with inpatient
44 care as well.
45
46 COMMISSIONER COCKRAM: Just to continue that question to
47 Dr Grigg: do you think that, and in your experience in some

1 of your past work, that the private system can offer
2 different components of streaming around either particular
3 cohorts or different diagnoses?
4
5 DR GRIGG: I certainly do, and it may turn out to be one
6 of the most efficient ways. So, the private hospitals
7 offer a model of care that, for example, for older
8 vulnerable consumers is often a really, really good model
9 of care and often reflecting the need for slightly longer
10 admissions into units.
11
12 I think that there is a design issue. I would
13 encourage. Inpatient care is just one of the offerings in
14 the private sector. Also thinking about how we can grow
15 and develop more stronger links with private psychiatrists
16 and private psychology, both of which I'm lucky I'm at an
17 organisation for a range of reasons we probably don't
18 experience the workforce pressures around psychiatry and
19 psychology that I'm aware many mental health services do.
20
21 But I think that it is really important to think about
22 the ways in which we can make sure that that into a
23 redesigned system, we're effectively using all of the
24 assets that that system has, and there's a lot of assets in
25 the private system that I don't think we've thought about
26 how to use as effectively as possible.
27
28 COMMISSIONER COCKRAM: Thank you.
29
30 THE CHAIR: Thank you. Professor McSherry.
31
32 COMMISSIONER McSHERRY: Yes, just a question for
33 Ms Anderson. You've explained the difference between
34 co-design and co-production very well in your statement,
35 and we've heard today about the importance of hope
36 throughout the system and the importance of peer workers in
37 general.
38
39 I'm just wondering, do you have a view as to what
40 would help the most to facilitate co-design and
41 co-production? Is it a matter of leadership, or is it a
42 matter of giving more power to various consumer
43 organisations, or a bit of both?
44
45 MS ANDERSON: I think, if we look at the current setting
46 of inpatient units, I think the UK has a really good
47 toolkit on experience-based design and I think that's a

1 starting point in the design of services, I think we can
2 build on that, and I don't think it's too complicated.
3
4 A lot of co-design and co-production processes can get
5 very complicated and they're not able to be replicated at
6 different services, so I think that it's a very good
7 example from the UK about experience-based design and how
8 they've implemented that into the everyday running of the
9 service.
10
11 COMMISSIONER McSHERRY: And, just to follow up, in terms
12 of co-production, is it better at this stage to think about
13 funding smaller projects and processes with the hope of
14 ramping them up, or should it be like a top-down system, so
15 that there's some sort of mandatory role that services must
16 have co-production throughout? Do you have a view on that?
17
18 MS ANDERSON: I think it's both, and I think it is a bit
19 of top-down and grassroots learning around that. I think,
20 if you start off in terms of smaller projects that can
21 support a set of champions that belong to services that can
22 go out and talk to their service, but I also think it needs
23 the management and the leadership to be on board around the
24 process; it's not just some consumer idea that's come in
25 and we don't give it much credence, we'll just nod our head
26 and tick the box, I think it needs management, so I think
27 it needs that mandated process as well.
28
29 COMMISSIONER McSHERRY: Great, thank you.
30
31 THE CHAIR: Professor Fels.
32
33 COMMISSIONER FELS: I wonder if we could hear from one or
34 two of the witnesses - maybe Ms Anderson to begin - on the
35 role of families and carers in all of this, including in
36 governance and in system design, but participation and so
37 on.
38
39 MS ANDERSON: I think it's good for families and carers -
40 well, families and carers have their own needs around
41 mental health issues and I think their needs are not being
42 met at the moment in the current system.
43
44 I think that the - I can't speak on behalf of families
45 and carers, but I think in terms of a person having
46 connectedness, meaning, supporting their identity and being
47 empowered, the families need to be involved, definitely if

1 that's possible from a consumer perspective.
2
3 DR GRIGG: I might add Professor Fels, because I think
4 that I've talked about recovery, you know, from personal
5 recovery, I've talked a little bit about recovery and
6 organisational and team recovery. But also, particularly
7 the families we work with also going through their recovery
8 journey, the experience of families, not just of the
9 illness itself and what that means in families, but often
10 their experiences, very negative experiences of attempting
11 to use the service system are often really, really
12 difficult.
13
14 And I think that, you know, I try to use the word
15 "lived experience workforce" to really talk about finding
16 ways to appreciate various lived experience, both
17 individual and from family and carers. And also
18 recognising that we actually have a significant number of
19 people who have lived experience of both; from both a lived
20 experience of their own mental health issues, but actually
21 also ended up in caring roles, and that it's quite a
22 complex and fluid issue and one - you know, I would
23 certainly say and acknowledge, from this organisation's
24 perspective, that we have not done anywhere near enough
25 work to really think about the ways in which the experience
26 of family and carers are integrated and connected to think
27 of that into the way in which we design our service and go
28 about doing our business, I think that's such an important
29 topic.
30
31 COMMISSIONER FELS: Thank you. Now, I had one other
32 two-part question, or two questions maybe for Peter Kelly.
33
34 The activity-based funding: as you know, when people
35 first thought of that in the 1960s, I think the very first
36 really serious bit of work on it mentioned "mental health
37 would be especially difficult", and I wondered if you could
38 say a touch more about the challenges and benefits of
39 activity-based funding.
40
41 And, secondly, not totally unrelated, and something
42 you touched on in one of your answers, or more than that:
43 we have in Victoria, in Australia, in the world, massive
44 geographic inequity right across the system. Have you any
45 general thoughts on, you know, what we do about it after
46 all these years of not having been terribly successful?
47

1 MR KELLY: Well, two good questions. I think firstly the
2 activity-based funding is a tremendous challenge for mental
3 health services. My understanding is, it's not been
4 successfully implemented, an activity-based funding model,
5 anywhere successfully in the world for mental health
6 services. I think that was the whole point of shadowing
7 the system for a year to see how the two systems run in
8 parallel and whether there are perverse incentives or
9 disincentives built into the system that were unintended
10 artifacts, if you like, of the model.
11
12 But I think the group that's been pulled together to
13 work on this, I think, have pretty high levels of
14 confidence that the model could succeed and could deliver
15 what it's intending to in terms of sort of mandating or
16 specifying the types of interventions that have to be
17 provided for each consumer when they enter a service.
18
19 And, you know, just in our own service for instance,
20 we mandate six interventions: so, psychological
21 interventions, family and carer work, health and wellbeing,
22 vocation, lived experience, and overcoming hurdles as six
23 sort of modalities that every consumer should receive when
24 they enter the service. An activity-based funding model is
25 a way to ensure that those things are delivered and
26 delivered to a satisfactory standard.
27
28 It's an interesting space to be involved in because
29 these are, some people that have been involved in the
30 system for 35 years and grappled with this issue a number
31 of times over that time period, but I think the time is
32 right.
33
34 COMMISSIONER FELS: Inequity?
35
36 MR KELLY: Well, again, a big challenge. The inequities
37 exist in Metropolitan Melbourne, as you've pointed out, but
38 in rural and remote Australia and, it is a fact of life,
39 and it's something that needs to be addressed via a
40 re-organisation of catchments or a re-organisation of
41 funding. But it seems to me that it's a combination of
42 population-based planning along with a closer and clearer
43 look at the demography in a particular area.
44
45 I often use the discrepancy between St Albans and
46 Toorak, for instance: they are poles apart for a whole heap
47 of reasons, not the least of which is income and level of

1 private insurance coverage as two examples, but access to
2 good education, housing, unemployment rates.
3
4 And, it's sort of a bit of a fact, isn't it, as
5 housing becomes tighter, people on the margins get pushed
6 further and further out of Metropolitan Melbourne. It
7 wasn't that long ago that Melton was seen as sort of the
8 fringe where people went when they couldn't get access to
9 good rental housing in St Albans or Sunshine, but it's
10 further afield now as the market tightens up.
11
12 I don't the have solutions, I'm just acutely aware of
13 the problem because I experience it every day, as I'm sure
14 consumers do as well.
15
16 THE CHAIR: Thank you.
17
18 So, thank you all, panel members, for your very
19 considered input. As I think my introductory comments and
20 that of Stephen O'Meara highlighted, this is really a
21 foundational piece for the design of our future mental
22 health system here in Victoria. None of the answers are
23 straightforward and we as Commissioner are grappling with
24 the very hard decisions we might need to make in terms of,
25 how do we overcome some of the current deficits in the
26 system and today's discussion has been very helpful to us,
27 as has our consideration of your individual witness
28 statements.
29
30 We will also potentially take up some of the
31 suggestions that you've made and follow through on some of
32 the ideas that you have highlighted today in our
33 discussion, and we thank you very much for the contribution
34 that you've made to our deliberations, so thank you very
35 much.
36
37 MR KELLY: Thank you.
38
39 MS ANDERSON: Thank you for the opportunity.
40
41 THE CHAIR: So, I think that's probably it, we've got an
42 early leave pass probably because, Stephen, you made us run
43 straight through in terms of the length of time, but I
44 think that's really helpful given the nature of the
45 discussion. Thank you very much, we'll speak to you again
46 all soon; bye.
47

1 **AT 12.47PM THE COMMISSION WAS ADJOURNED**
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