

ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Held via Zoom

On Wednesday, 24 June 2020 at 9am

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

1 THE CHAIR: Good morning everybody. Thank you very much
2 for taking the time to be with us and I'll now start
3 formally our panel hearing.

4
5 Welcome to the Royal Commission panel discussion on
6 community-based mental health services. I'm Penny
7 Armytage, the Chair of the Royal Commission into Victoria's
8 mental health system. I am joined by my fellow
9 Commissioners: Professor Allan Fels, Dr Alex Cockram and
10 Professor Bernadette McSherry.

11
12 On behalf of the Commission I acknowledge Aboriginal
13 peoples as the traditional owners across all of the lands
14 on which we locate for today's panel discussion and I pay
15 my respects to their Elders past, present and emerging.

16
17 First, I would like to extend my sincere thanks to
18 Elizabeth Deveny, Associate Professor Stephen Moylan and
19 Nicole Bartholomeusz for taking the time to participate in
20 today's panel discussion.

21
22 I appreciate the significant amount of time and energy
23 that you have devoted to developing your comprehensive
24 witness statements in preparing for today's discussion.
25 Your time and efforts are all the more precious within the
26 context of the current pandemic. As healthcare leaders,
27 you are all guiding Victoria through this challenging time.

28
29 Today's panel presents an opportunity to discuss and
30 debate what these reforms should look like in terms of the
31 context of our community-based settings. Importantly, I
32 say "debate" because there are not clear-cut issues. I
33 invite you to speak your minds about issues that may be
34 controversial or consider difficult trade-offs. We cannot
35 lay the foundations of sustainable and implementable reform
36 without considering all complexities.

37
38 Today we are turning our mind to community-based
39 mental health. Community-based care is broadly defined.

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41 As panellists you represent three key pillars of
42 community-based care: area mental health services,
43 community health organisations and primary health networks.

44
45 Many more services, settings and practitioners make up
46 the current patchwork of community-based mental health care
47 in Victoria. In discussing community mental health care in

1 Victoria we are conscious of the history in Victoria over
2 the past three decades. When de-institutionalisation
3 progressed through the 1980s and 90s there was a major
4 shift to mental health services in the community.
5

6 The 1994 framework for the mental health system in
7 Victoria highlighted community-based care as the preferred
8 way of providing care, treatment and support for people
9 experiencing mental illness.
10

11 Experts have told the Commission that the
12 community-based principles that underpin Victoria's
13 de-institutionalisation efforts, and I quote "remain
14 indisputably valid today." However, the Commission has
15 heard extensive evidence that Victoria's initial investment
16 in community-based mental health services has not been
17 sustained. The result is a patchwork of community-based
18 services across the state.
19

20 The Commission understands that, whilst Victoria was
21 once a national leader in community-based mental health
22 care, Victoria now lags behind other States and
23 Territories.
24

25 Reductions in funding and community-based service
26 offerings directly impact mental health consumers. At our
27 community consultations in Sale last year one consumer told
28 the Commission:
29

30 *I tried to connect with community mental*
31 *health services but, until a crisis*
32 *occurred, I got nothing.*
33

34 People have told the Commission that even when they do
35 gain access to services, these services are often not
36 holistic. The Commission has heard that too often services
37 fail to see the whole person, focusing on only one facet of
38 a person's experience and failing to address others.
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40 For example, as Associate Professor Dean Stevenson,
41 Clinical Director at Mercy Mental Health told the
42 Commission last year:
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44 *Your psychosocial supports and your*
45 *psychosocial tools become lost with the*
46 *focus on, well, what tablet are we going to*
47 *give you now to see whether that will help*

1 you or not?

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Service providers have emphasised that, while medications and biological interventions can be important to recovery, they are sometimes prescribed in isolation from other strategies that could improve wellbeing.

It is clear that across your statements that you share broad consensus around the essential role of community-based mental health care in the future system and the need to make this care more integrated and multidisciplinary.

You also put a spotlight on systems and service fragmentation, highlighting the need for improved governance and funding arrangements and the need to measure outcomes for consumers. You all spoke about the need to better support our workforce and unlock the potential of digital and telehealth.

From today's panel the Commission is particularly interested to understand in a rationed system and with an obligation that reforms be sustainable and actionable, what should be the core components of care in a community-based mental health system into the future, how might we think about what should be available at a local, regional and statewide level in a future system, and how should the Commission consider balancing consistency across the State with opportunities for local innovation that meets the needs of local communities.

Today's discussion will seek to explore reform directions proposed in your witness statements. This will support us as a Commission to better understand our windows of opportunity to drive meaningful change in this area.

I would like to emphasise that today's deliberation is just one way that the Commission will obtain information on this issue. We remain committed to placing the views and experiences of people with lived experience at the centre of all of our inquiries. Insights and recommendations will continue to be sought from consumers, carers and families on this issue as well as representatives from mental health and other sectors.

Finally, before I hand over to Senior Counsel Assisting, Stephen O'Meara QC, who will facilitate today's

1 discussion, I would like to once again thank you for your
2 time in assisting the Commission with our inquiries. We
3 look forward to a robust and insightful discussion on this
4 difficult but very important topic today. Thank you,
5 Stephen.

6
7 MR O'MEARA: Thank you very much to the Chair for your
8 introductory remarks and for identifying the issues and
9 areas of interest which I won't repeat in my own very brief
10 opening remarks.

11
12 Before doing that, I'd like to thank all of the Royal
13 Commissioners and the Commission staff for identifying the
14 important topic the subject of today's panel discussion.

15
16 Community-based mental health is an area of very real
17 interest and importance and at the heart of the work of the
18 Commission. As you will already have heard from the Chair,
19 it's important that multidisciplinary support of mental
20 illness in community-based settings be properly understood
21 and considered carefully as to its components and other
22 elements in any system going forward.

23
24 At this point I should introduce our panel members and
25 commence by thanking them in advance for their time,
26 enthusiasm and generosity. Without their contributions
27 and, for that matter, the contributions of the many
28 witnesses with whom the Commission has had contact, the
29 work of the Royal Commission couldn't proceed and certainly
30 not at this time affected as we are by the pandemic.

31
32 All three of today's panel members are well qualified
33 to give evidence in connection with today's topic.
34 Starting then in no particular order: our first panel
35 member is Dr Elizabeth Deveny. Ms Deveny has a Masters
36 Degree in vocational education from the University of
37 Melbourne and a PhD in medicine on the topic of clinical
38 decision-making. She has long experience in managing the
39 provision of health services. Since 2015 she's been the
40 Chief Executive Officer of the South Eastern Melbourne
41 Primary Health Network. Since May 2017, she's been a
42 member of the Southern Metropolitan Partnership, which
43 advises the Victorian Government, and she is also a member
44 of the Australian Digital Health Agency and has been Chair
45 of that agency since July 2017.

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47 Our second panel member is Associate Professor Steven

1 Moylan. Associate Professor Moylan completed his training
2 in psychiatry in 2016 and has a PhD in psychiatric
3 epidemiology from Deakin University. He also has a Master
4 of Public Health from the Harvard TH Chan School of Public
5 Health. He has worked at Barwon Health in Geelong since
6 2008, and since April 2018 he's been the Clinical Director
7 of Mental Health, Drugs and Alcohol Services at Barwon
8 Health, a service that has more than 400 specialist
9 clinicians and support staff. He is also a non-executive
10 director at On the Line, a professional social health
11 organisation that provides counselling support for men's
12 mental health.

13
14 Our third panel member is Nicole Bartholomeusz.
15 Ms Bartholomeusz has a Diploma of Applied Science and a
16 Graduate Diploma in Community Health. In 2005 she obtained
17 a Master of Business Administration from La Trobe
18 University. She has long experience in the management of
19 health services, including since 2014 in several roles at
20 cohealth, a not-for-profit community health organisation
21 that delivers low cost, high quality and accessible
22 healthcare and support services across Melbourne's CBD and
23 northern and western suburbs. Since September 2019,
24 Ms Bartholomeusz has been the Chief Executive of cohealth.

25
26 On behalf of the Commission may I welcome each of our
27 panel members warmly, and I should mention that each of our
28 panel members has prepared a detailed written witness
29 statement in response to some questions posed by the staff
30 of the Royal Commission and in due course those witness
31 statements will be made available via the Commission's
32 website.

33
34 Each of our panel members will now confirm that
35 they'll be giving evidence today just as if we'd been
36 assembled at a hearing face-to-face. For that purpose,
37 might I start first with Associate Professor Moylan, if you
38 could just confirm that.

39
40 ASSOCIATE PROFESSOR MOYLAN: Yes, that's correct.

41
42 MR O'MEARA: Thank you, and Ms Deveny - Dr Deveny I should
43 say.

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45 DR DEVENY: Everything is fine, that's correct, thank you.

46
47 MR O'MEARA: Before I move on, I don't want to annoy you

1 for the next two and a half hours. So, the proper
2 pronunciation of your surname, have I got that right?
3
4 DR DEVENY: Yes, that's right, "Deveny".
5
6 MR O'MEARA: Thank you. And finally, Ms Bartholomeusz?
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8 MS BARTHOLOMEUSZ: Yes, that's correct.
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10 MR O'MEARA: Thank you. For the benefit of those who have
11 come to watch this hearing, all panel members participated
12 in a conclave roughly a week ago in which many of the
13 issues the subject of today's exchange were discussed, but
14 in the course of that conclave there were some areas or
15 matters that were broadly agreed between the panel members
16 concerning the topic of community-based mental health. I
17 might just get each of you to confirm a group of those for
18 me because they have been identified between you.
19
20 I'll start with the first three and then just ask one
21 of you to confirm them. The first three are that,
22 supporting the mental health of consumers is facilitated by
23 integrated multidisciplinary care and a continuous model of
24 care. Also, that there is fragmentation in the space
25 between acute or tertiary bed-based care and primary care,
26 and thirdly, that there's an important role for
27 community-based treatment and support of mental health.
28
29 And now that I know how to pronounce your name
30 correctly, Dr Deveny, can I ask you to confirm those three
31 for me?
32
33 DR DEVENY: Yes, I'm happy to confirm those.
34
35 MR O'MEARA: Thank you. Then the next two are:
36 community-based mental healthcare can have an important
37 role in supporting consumers with mild, moderate and severe
38 and chronic presentations as well as supporting families
39 and carers, as well as that there are important
40 (indistinct) issues of governance and funding.
41 Ms Bartholomeusz, perhaps if I could get you to confirm
42 those.
43
44 MS BARTHOLOMEUSZ: Yes, I confirm those.
45
46 MR O'MEARA: Thank you, and again finally, that there's a
47 need to measure outcomes, not just inputs or throughput;

1 that there are potentialities, to some extent already
2 realised, in the delivery of digital and telehealth, and
3 that the capacity in the community-based mental health
4 workforce must be both built and rebuilt. Associate
5 Professor Moylan, your turn this time.

6
7 ASSOCIATE PROFESSOR MOYLAN: Very happy to confirm that.

8
9 MR O'MEARA: Thank you. Ms Bartholomeusz, moving then to
10 the areas of discussion that have been identified, there's
11 a couple of things that might be relevant to the setting in
12 which we discuss these issues, and the first really is what
13 in the course of the conclave was identified as social
14 determinants and, when addressing those issues which came
15 up in various ways in the course of that discussion, you
16 described the prospect or the problem of band-aiding in
17 discussing dealing with the social determinants as a
18 backdrop to community-based mental healthcare.

19
20 I wonder if you could address and identify what the
21 social determinants are and the problem of band-aiding as
22 you see it and that that needs to be borne in mind when
23 discussing and considering how it might be that the
24 community-based mental health system could function in this
25 State.

26
27 MS BARTHOLOMEUSZ: Thank you, I'm happy to respond to that
28 question. I last week spoke to the concern that, if we
29 continue to only respond to the presenting issue or
30 problem, that we are merely applying a band-aid; that, if
31 we look at - if we took an approach that actually dealt
32 with the social determinants of health, so we looked at the
33 underlying drivers for what was driving health inequality,
34 understood what - the reasons why people had poor health
35 outcomes and address those drivers, that we actually would
36 be able to prevent many of the health challenges
37 (indistinct) mental health.

38
39 And so, those social determinants are all about a
40 person's education, poverty, housing, ability to access and
41 maintain secure employment and, if we can focus our efforts
42 on addressing those social determinants, so putting those
43 structures in place, then we will actually in the long-term
44 address many of the drivers for poor mental health.

45
46 MR O'MEARA: Thank you. Another element of the setting
47 for the consideration of the present issues concerns

1 stigma, which also came up in a number of different ways in
2 the course of our conclave last week. Associate Professor
3 Moylan, if I can ask you to address those elements, that's
4 something that you spoke to in several different ways in
5 the conclave discussion.

6
7 ASSOCIATE PROFESSOR MOYLAN: Thank you, Stephen. I think
8 the Commissioners would have heard much about stigma
9 through written testimony and through the testimony of the
10 people with lived experience, so I wouldn't want to pass
11 that too much, but I feel like stigma does permeate our
12 community mental health system in many more ways than just
13 individual response to treatment and care.

14
15 I suppose some of the points we discussed last week
16 were regarding people's access to care, people's perception
17 about accessing care, the stigma that related to the health
18 workforce in providing care in certain environments, how
19 stigma has permeated the investment and the expectations of
20 care in a community-based setting, and also I think how
21 stigma has permeated how we've governed the system in some
22 regards.

23
24 So, I'm happy to pull apart some of those things as we
25 go through the discussion, but I feel that it's important
26 for the Commission to acknowledge the really strong
27 permeated impact that stigma has had all throughout the
28 system on all of the participants involved. Thank you.

29
30 MR O'MEARA: You might also speak to your own personal
31 experience of feeling that stigma at times.

32
33 ASSOCIATE PROFESSOR MOYLAN: I think it's important to
34 acknowledge that, for people like us, I think all of the
35 people here who are interested in providing a more robust
36 delivery system and care system for people experiencing
37 mental distress, there is a cost to that in our current
38 society, and that cost has been borne by me personally and
39 I've shared this with other people before.

40
41 Unlike many of my colleagues, I have been the subject
42 of abuse in public places because of the role that I've
43 played providing care or overseeing a care system, and I
44 think that's one of the - and I've also had many colleagues
45 who have experienced the same thing. So, I think that's
46 something to recognise, that the degree of permeation of
47 stigma and the kind of I think general fear that underpins

1 some of that from some parts of our community doesn't just
2 affect our consumers but it also affects care deliverers,
3 which by virtue of course affects our consumers, so there
4 is a real mix of these things which are important to
5 acknowledge.

6
7 MR O'MEARA: Thank you. Dr Deveny, having identified some
8 of the, if you like, backdrop or settings in which our
9 present discussion occurs, I wonder if we can move then to
10 discussing the system, with you to address it first; the
11 need to, in considering what the system can look like, the
12 need both to agree, as you identified last week, upon what
13 constitutes good practice and the difficulties when
14 considering what to be done with a system of introducing,
15 if you like, new pieces of furniture or what you describe
16 as new doors. I wonder if I can ask you to kick off on
17 that topic?

18
19 DR DEVENY: Certainly, I'd be pleased to, Stephen. I'd
20 like to start by saying, I think better is possible and
21 this can appear a challenging area, but I don't think that
22 it's impossible for us to make significant improvements.

23
24 There are five key points for me here. The first
25 relates to using funding more efficiently, and I think
26 that, particularly in the current fiscal environment, it
27 would be unreasonable to expect significant resources to be
28 devoted into those that are already available, and I would
29 make the argument that we can use the money we have better
30 to better align the activities of people across various
31 funding sources.

32
33 My second point relates to your comment about
34 component parts. I think we need to better understand or
35 audit the component parts that already exist in the system
36 before we move to thinking about whether we need a new one.

37
38 So, the example here I might give is simply, when we
39 decide we need a different kitchen, we don't normally break
40 down the whole house and start again because we don't have
41 the money; we have the component parts, we may just need to
42 make a few changes.

43
44 Then I think my third point here is that, we need to
45 agree what good looks like, we need to understand if the
46 component parts are all we need, so that notion of what is
47 good practice in a primary care or community setting.

1
2 Then the fourth point relates to, knowing that that's
3 what we're getting, so this is when we start to talk about
4 outcomes, the collection of data both at a population
5 health level, but also at the individual level. So, here
6 I'm talking about patient reported experiences of care and
7 outcome measures.

8
9 All of this takes - really the fifth point that I want
10 to make in relation to your question, Stephen, which is
11 leadership. I don't think anyone would argue there's been
12 a lack of leadership in mental health. You could be
13 knocked over by the crowd of people who have expertise and
14 want to lead this area.

15
16 I think what we need, though, is for our leaders to
17 agree what it is we're trying to do collectively and I
18 think, by agreeing the component parts, understanding what
19 good looks like and then agreeing how we'll measure that,
20 we'll give our leaders a very easy task of simply keeping
21 people accountable to those key areas.

22
23 MR O'MEARA: Thank you for introducing the topic and the
24 considerations in the topic. Each of you has got a
25 different perspective on community-based mental health
26 practice because each of you is centrally involved in a
27 service with a different perspective.

28
29 I might, in order to develop the discussion of what a
30 community-based health model might look like, ask for you
31 each to identify what your service does and what your own
32 experience is in order that that perspective might be made
33 clear.

34
35 I might start with you, Ms Bartholomeusz, because
36 cohealth has six - I was about to double the number - has
37 30 different sites of operation in northern and western
38 Melbourne, and it's also apparent from your statement the
39 different sources of funding that you need to rely upon in
40 order to run the programs that you're running; some from
41 DHHS, some from the Commonwealth and so on.

42
43 I wonder if you can speak to what your service does
44 and the model it operates under?

45
46 MS BARTHOLOMEUSZ: Thanks, Stephen. So, cohealth is a
47 large not for profit community health service provider in

1 the north western CBD of Melbourne. As Stephen said, we
2 have approximately 30 sites across that geographical area
3 and provide a whole range of community health services
4 along the healthcare continuum; so, from health promotion,
5 education, prevention, early intervention, into treatment
6 services, and I think that is a, you know, a strength of
7 the community health sector in being able to provide a
8 range of services.

9
10 So, within that range of services is a community-based
11 mental health service focusing on the very marginalised and
12 vulnerable communities in those geographical areas.

13
14 A key element of the work that we do is psychosocial
15 rehabilitation and working within the collaborative
16 recovery model, so working with individuals to ensure that
17 they are able to self-manage their mental illness, but also
18 be able to continue to function and remain within
19 community. So, providing a range of social support
20 services that enable clients experiencing mental illness to
21 be able to self-manage, but also then finding that kind of
22 person-centred holistic approach to the care that we
23 provide.

24
25 So, not just focusing on the presenting mental
26 illness, but also thinking about the physical health needs
27 of that individual and being able to provide a range of
28 wrap-around physical health services that that individual
29 might need, and that might be connecting them with general
30 practice, or providing access to public oral health
31 services. It could also be - we're not a housing provider,
32 but we do have strong partnerships with housing providers,
33 so, it might also be about making a connection for that
34 individual to a housing provider so we can support their
35 access to secure housing.

36
37 So, it's really around sort of looking at the needs of
38 the client, working with the client to identify what their
39 goals are, and then either providing that care directly
40 ourselves, or partnering with other organisations to
41 provide the broader social support services. And, in doing
42 that, really work to trying to achieve better outcomes for
43 that client, but noting that their outcomes are defined by
44 the client, not by the organisation or by the clinician or
45 the support worker.

46
47 Another key piece of our work, is, as I talked about

1 earlier, is the focus on the social determinants, so
2 continuing to shape and influence public policy that
3 improves the health equity of these vulnerable populations,
4 so really working in the space of trying to, such as the
5 Royal Commission into mental health, but really trying to
6 address system-wide issues that will improve the health
7 outcomes for individuals.

8
9 MR O'MEARA: Thank you. While I've got you, you referred
10 to the 30 different sites and you've spoken of what your
11 organisation does across those sites, but is the Commission
12 right to understand that there's variation or local
13 variation in the services that are provided from site to
14 site and, if that's the case, you would have heard the
15 Chair refer to what were described as core components in
16 service delivery in each of those places.

17
18 Is that something that you - is that a principle
19 that's applied in your sites? Do you have core components
20 of service that you must provide in each site and, if so,
21 then there must be optional components and, if so, what are
22 they?

23
24 MS BARTHOLOMEUSZ: Thanks, Stephen, and I also didn't
25 respond to your earlier question about funding
26 arrangements, so perhaps I'll pick that one up first.

27
28 MR O'MEARA: Sure.

29
30 MS BARTHOLOMEUSZ: So, we are funded predominantly by
31 State government, but we also have some Commonwealth
32 funding and there's also some local government funding and
33 philanthropy, so we have a range of funding sources.

34
35 And through that range of funding sources we actually
36 look at what the needs of the clients are, the services
37 that are required to respond to those needs, and then how
38 do we bring in the various pieces of funding from different
39 levels of government to actually deliver a service. So, we
40 get very creative with being able to tap into certainly,
41 you know, State-funded mental health dollars, but also then
42 we have seven general practice clinics across our network,
43 so tapping into MBS [Medicare Benefits Scheme] funding;
44 we're also funded by the PHN [Primary Health Network], so
45 for mental health nurses, so pooling all of those funding
46 resources together, developing a model of care, and
47 delivering that model of care in terms of meeting the

1 client need.

2

3 So, the issue of funding is extremely complex and with
4 that range of funding comes a whole lot of issues around
5 compliance, reporting and system requirements.

6

7 So, across our 30-odd sites that we have, they do all
8 have - I like to say that one of the strengths of community
9 health is our ability to meet the needs of a local
10 community, and so, if you look at our 30-odd sites that we
11 have they all have a very different look and feel depending
12 on the need of the community that we're working with.

13

14 So, if you take our central city location in Melbourne
15 CBD, it has a particular focus on working with the homeless
16 population that live in the centre of Melbourne. It
17 provides a range, so there are a core group of services
18 that we provide, so general practice and allied health
19 services, but then there's also services that are designed
20 to meet the needs of that population; so, we have laundry
21 service, we have shower facilities, we partner with a
22 housing provider to provide support into housing. We
23 partner with area mental health service around the mental
24 health needs of that community. We have alcohol and drug
25 services also based there responding to the alcohol and
26 drug issues that this community has, so that's one example.

27

28 If you went to our major sort of practice in
29 Footscray, you know, there is a big oral health clinic
30 based there, general practice, full range of allied health
31 services, domestic violence, counselling services. So,
32 each clinic, you might like to call it, has a very
33 different look and feel.

34

35 We also have some residential based mental health
36 services in the north; again, a very different look and
37 feel, but we will bring in - so we in-reach, out-reach or
38 in-reach into those facilities with a range of health
39 service providers to meet the needs of those clients.

40

41 MR O'MEARA: Does it follow from what you're said that the
42 therapies are not just the - if you like, the composition
43 of the workforce in each of the sites might vary but the
44 therapies applied in those sites, be they psychological
45 therapies or other programs, vary from place to place?

46

47 MS BARTHOLOMEUSZ: Yes, they also vary and some of that

1 variation is due to funding and the capacity of the site to
2 deliver the service. So, dental, for instance, is a very
3 expensive service to deliver and a very expensive service
4 to establish. So, we have three major oral health clinics
5 and, if a client requires an oral health service that's not
6 at the clinic that they usually attend, then we assist with
7 a warm referral into one of our other sites to ensure that
8 the client does actually receive the care that they need.

9
10 MR O'MEARA: Thank you. On the topic of funding,
11 Dr Deveny, you have a particular perspective on
12 community-based mental health and involvement in it because
13 of the centrality of the South Eastern Melbourne PHN to
14 funding all kinds of elements of the system in your region,
15 I wonder if I can get you to speak to your perspective on
16 it.

17
18 MS BARTHOLOMEUSZ: Yeah, thank you, Stephen. I think this
19 is really core to the issues raised at the beginning by the
20 Chair. So, our role as a Primary Health Network is to
21 commission services, in this case we're talking about
22 community-based mental health services. In order to do
23 that, we begin by understanding what funding is available
24 because we do ration services.

25
26 Then we look at two things in the broad: we look at
27 the population health needs, and so, that speaks to my
28 earlier point, the fourth point I made about understanding
29 your data and what you need to achieve. Then we also look
30 at current service availability; this is often called
31 service mapping. And, if you like, we overlay these two
32 things: what does the data tell us a community needs? And
33 then, what is already available?

34
35 We know that there are many more services available
36 the closer you get to the city, and that's partly just an
37 historical fact: a city, a town, a suburb, has been around
38 longer, the chances are it has more services, so generally
39 we find that the outer parts of Melbourne have less service
40 availability and often higher need.

41
42 In relation to your comment about variation, I would
43 say that variation based on services meeting population
44 health needs, which I think is the comment that my
45 colleague also made, should not be a matter of concern.
46 Unwarranted clinical variation is a matter for concern, not
47 variation in the services that are available.

1
2 From this point we then co-design services, often with
3 clinicians, service providers, community carers and
4 experts, so that the services meet the requirements of
5 their clients, and we do this within the context of our
6 broader stepped care model. So that, as you bring a new
7 service in, we are very mindful about not further
8 fragmenting the service system. We want to understand how
9 that element will fit with everything else that we do so
10 that, from the client's perspective, the journey is
11 smoother.

12
13 We then have a pretty standard tendering process with
14 probity and the like, and the consequence of this is that
15 we're viewed as an honest broker. We're not the
16 researchers, we're not the service providers, we're not the
17 funders. Our job is to make sure the funding is used
18 effectively, transparently and with high accountability.

19
20 When we contract our service providers we make sure
21 they understand all of this. We agree with them, and this
22 is my point earlier, we agree what good looks like, the
23 third point I made, and what data will be collected, and
24 then jointly with the service providers and ourselves we
25 lead, if necessary, any change. That's primarily our role.

26
27 We also undertake some capacity building. So, the
28 point that the three of us made at the conclave was that
29 capacity building in the workforce is quite important. So,
30 when we're bringing in a new piece particularly, but not
31 only if it's a change, we run communities of practice, we
32 might provide other mechanisms, for example secondary
33 consultations or other funding, to try as best we can
34 within our funding parameters to increase the skills and
35 capacity of the workforces delivering our services.

36
37 MR O'MEARA: Thank you. Associate Professor Moylan, you
38 come at this from a different perspective. Can I ask you
39 to speak to the operation of your area mental health
40 service at Barwon and also the connection that you've
41 sought to establish and you speak to in your witness
42 statement with the Bellarine Community Health service?

43
44 ASSOCIATE PROFESSOR MOYLAN: Sure. So, for purposes of
45 background, Barwon Health is the area mental health service
46 provider for what is broadly the G21 Local Government
47 Areas, so we cross over the Greater City of Geelong,

1 Queenscliff, Surf Coast, Colac, Otway and Golden Plains
2 Shires - cities, I should say - and that's about a
3 catchment area of just over 300,000 people but quite a
4 disparate population, the majority of it's centralised
5 locally in the Geelong region but spreading all the way
6 down to Apollo Bay. So, I feel we have an interesting
7 spread of kind of inner urban plus very rural population
8 needs, and I think that speaks a little bit to the need for
9 localised variation in service delivery.

10
11 When I consider what our role is in the entire service
12 system, I really identify that our services provide - we
13 provide services to two groups really. The first group is
14 an "a diagnostic group", so no particular diagnosis, but a
15 group of people who are at high individual risk or risk to
16 others at a particular point in time because of crisis.
17 And that service delivery is provided through our
18 connection with emergency-based services, emergency
19 departments, ambulance, police, and the notion that we are
20 the 24-hour provider of services in our region as a
21 provider of last resort. I term that for our team, we're
22 kind of the safety net for our region.

23
24 The second group that we provide services for are
25 people who have severe, you know, moderate to severe
26 functional impairment and our role is to partner with them
27 around rehabilitation to improve functional impairment over
28 time. I think it's important for the Commissioners to
29 realise that from my perspective, the individuals that I'm
30 working with have problems and conditions that come with
31 significant morbidity and risk of mortality, and these are
32 complicated conditions that cross over not only in
33 psychosocial domains but also physical health domains, and
34 the connection with our - as a health service broadly, not
35 just as a mental health service broadly, is really
36 important around identifying that.

37
38 Because, as people would recognise, people's mental
39 health conditions that require treatment don't necessarily
40 present with classical mental health symptoms or
41 structures; they can present in physical health ways and it
42 speaks to the real need for integration with broader health
43 to understand a person's needs holistically.

44
45 Stephen, you'd have to remind me of where you'd like
46 to go because I was sort of on a roll there, so help me
47 out.

1
2 MR O'MEARA: That's all right. You're involved in the
3 crisis end of the system, that's what you were alluding to
4 in what you just said. The Commission's heard that one of
5 the functions of the community-based mental health service
6 is to protect that area. What are you protecting, why do
7 you need to protect it and, therefore, what does the
8 community-based mental health system need to do in order to
9 provide that protection?

10
11 ASSOCIATE PROFESSOR MOYLAN: Yeah, I mean, I come at this
12 from a different lens and the kind of analogy that I tell
13 the other areas of our health service in a way. I think
14 it's important to understand, at the moment we are
15 partnering with about 1,100 or 1,200 people in our
16 community across this region and about 30 of those people
17 are in our inpatient unit. So, the rest of those people
18 are based in the community, in their own homes, other
19 homes, or experiencing homelessness outside of the hospital
20 system. So, the actual breadth and depth of our
21 community-based infrastructure is really strong and
22 integral.

23
24 The way I kind of - you know, the analogy I say, and
25 I'm a doctor and I can't take that away from myself, so I
26 apologise in advance - but in a way our inpatient unit is
27 like our intensive care unit; this is a place where people
28 can come to receive stabilisation and care and, you know,
29 and a certain type of function that can help people in a
30 really pointy bit of crisis.

31
32 After that, I have the attitude that actually our
33 community-based care, like our general hospital setting, we
34 want to get people out of the ICU back into the general
35 hospital setting receiving multidisciplinary care so
36 they're on the journey back to health, and eventually - you
37 know, I hate to use the word "discharge" - but
38 collaboratively transferred back into a primary care
39 setting that requires less security and more breadth.

40
41 So, in terms of our community-based system, I think
42 it's actually integral. We operate highly specialised
43 multidisciplinary care for people with really complicated
44 needs with conditions with high potential - you know, high
45 morbidity and potential mortality in a community-based
46 setting, and the integration between the acute based
47 setting - so I'll call that bed-based or emergency-based

1 services and those things - has to be very tight, in the
2 same way that the integration between the intensive care
3 unit for lung disease or heart disease has to be very tight
4 with a respiratory unit on an inpatient unit.

5
6 Otherwise, what we're doing, we're at risk of
7 isolating off a very acute section and I think actually
8 making that more difficult to run, but also, we're at risk
9 that I would then have no influence or necessary control
10 over how we manage the intensive care that we're providing,
11 who we're doing that for and what the steps we can do at a
12 very proactive specialised sense to be able to keep people
13 out of that environment. So, that's where we, I think our
14 role, sits within that system.

15
16 In terms of the connection with the health service,
17 it's important for the Commissioners to know that Barwon
18 Health is unusual across the State where we actually also
19 run a community health program. So, my program is the
20 mental health and drug and alcohol services program, but
21 aligned with that is a community health program which runs,
22 amongst other things, community nursing practice, community
23 rehabilitation services, a community palliative care
24 service.

25
26 And so, we seek to partner with those agencies as well
27 because we also understand that, if our role or function is
28 to provide specialist multidisciplinary input, that doesn't
29 necessarily mean that we are the most qualified of
30 providers to provide community-based healthcare input
31 either in the sense of community nursing or other
32 psychosocial domains.

33
34 So, our community health program is one of our
35 partners, but across our region we have a small number
36 albeit of community mental health organisations that we
37 seek to partner with too about how can we improve our reach
38 into other areas, where because of our current funding
39 arrangements we wouldn't be able to necessarily do that,
40 but how can we improve that reach so we can leverage off
41 the capacity that these organisations have, and they can
42 leverage off our specialist input at the same time.

43
44 MR O'MEARA: Thank you. You referred also to the link
45 back to primary care. You've talked about the community
46 programs that Barwon Health has, but the link back to
47 primary care and you've described the GPs as the entrance

1 point to the system.

2

3 Can you explain to the Commissioners the importance of
4 the GPs or the primary carers to the operation of the
5 system within your region?

6

7 ASSOCIATE PROFESSOR MOYLAN: Yeah. The nature of our
8 health system at the moment is that the GPs are seen for
9 specialist care as the primary carers or the gatekeepers or
10 entrance points of the system to receive specialist-based
11 care and that's enshrined in a whole series of different
12 things; referral-based process for Medicare rebates is one
13 simple example. And we also know that general practice
14 sees far and away more mental health care than we see.

15

16 So, my wife is a general practitioner - I put that on
17 the table - she will see 30 or 40 per cent of her
18 consultations will relate to metal health related
19 conditions or mental health related distress at any one
20 point in time. And I was really taken, and I think one of
21 the issues that's happened with our systems is that,
22 because of you know, quite frankly, the denigration and the
23 deterioration in the community mental health system and the
24 area mental health system over time, there's been a
25 functional disconnect that's happened between general
26 practice and primary care and the system that we operate.

27

28 I was really taken by a comment last year actually at
29 one of the roundtables from a representative of general
30 practice who spoke about how general practice increases
31 their capability and capacity, and the way they do that is
32 through close and fast turnaround linkages with specialist
33 systems. So, if I'm a general practitioner and I want to
34 understand the latest treatment for a heart condition, I
35 send someone to a cardiologist, they get seen quickly and
36 they write back and they tell me, this is what we do. And
37 if I do that three or four times for similar things I get
38 to see, okay, the cardiologists are doing things this way
39 now, now I feel more capable and comfortable to be able to
40 do these things.

41

42 The issue that's happened with mental health care is
43 that it's so challenging now to get specialist-based input
44 and fast turnaround into things that the GPs, I think, feel
45 a little bit under-prepared for some of these things and
46 then feel uncertain about what to do. And we can speak to
47 that later about accessing private psychiatry in our region

1 and accessing acute-based specialist care as well.

2

3 So, I think there's been a functional disconnect and I
4 think if we can really improve that for general practice I
5 think we would find, in a capability building perspective,
6 and a confidence building perspective, that for users
7 accessing the system, they'll find that, when I go to the
8 GP I can get really good specialist-based mental
9 healthcare, but also, very fast turnaround into a
10 specialist system and come back to my GP who is the home of
11 my care.

12

13 MR O'MEARA: Thank you. Thank you, Associate Professor
14 Moylan.

15

16 Ms Bartholomeusz, talking about the components of
17 care, one of the things that's been mentioned so far is the
18 importance of physical health in clients who are suffering
19 also from mental illness. I wonder if you can speak to the
20 importance of physical health as you see it and the
21 importance of that part of - that component of care in your
22 service.

23

24 MS BARTHOLOMEUSZ: Thank you. We know it's, you know,
25 widely documented that people who experience longer
26 sustained mental illness have much worse physical health
27 outcomes. So, the approach we've taken at cohealth is to
28 establish multidisciplinary care teams where the provision
29 of mental healthcare and physical healthcare is integrated.

30

31 So, picking up on Stephen's point earlier around the
32 general practitioners, so again through our general
33 practice clinics the majority of our clients will come
34 through the general practice door. But we also have a
35 really large oral health service and we find that, for
36 people who are in the sort of marginalised and vulnerable
37 communities that we serve, they're not able to walk into
38 mainstream services and seek the care that they need.

39

40 A large number of our clients will present, so new
41 clients who then become ongoing clients of the service,
42 will actually present to our dental facilities for
43 emergency care because they're in pain, and it's usually an
44 episode of pain that brings people to our service. So,
45 it's really important for us at that point to not only
46 address the issue, the presenting issue of pain, but to
47 also be able to actually screen more broadly for other

1 health issues including mental health, and that then
2 provides an opportunity for us to refer internally within
3 the organisation to address the other presenting health
4 issues if the client, you know, consents to doing that.

5
6 We have taken an approach of, sort of, it works both
7 ways; so, ensuring that our workforce is skilled in
8 identifying potential mental health issues and referring to
9 the right place to have those issues diagnosed and worked
10 through, but also when a long-term client of the service
11 that we're working with, that we also address the physical
12 health needs. So, we know that - yeah, as I started saying
13 that clients who have long-term mental health conditions
14 their physical health is often overlooked, and I've heard
15 stories from clients where they've been to seven, eight,
16 nine, ten GP practices with a physical health condition
17 that has been overlooked because of their mental illness.

18
19 And so, we've really taken an approach to actually
20 ensure that we're providing services that also address the
21 physical health concerns that the individual might present
22 with, and that's been through the creation of
23 multidisciplinary teams to be able to do that, skilling the
24 workforce in both physical health and mental health
25 screening, and being able to provide that close, warm
26 referral either within the organisation or, if it's a
27 service that's required that we don't provide, externally
28 also.

29
30 MR O'MEARA: Thank you. Does it follow from the earlier
31 evidence that you've given that the identity or the
32 construction of those teams, that is, who's in them, will
33 vary from client to client, and could you give us an
34 example of what the membership of a team might typically
35 be?

36
37 MS BARTHOLOMEUSZ: So, you would have - it does, it does
38 vary from client to client depending on what the care plan
39 is or, you know, the outcomes that the client is seeking,
40 but you might have a mental health specialist worker, a
41 care coordinator or a care manager that co-ordinates that
42 care, and then a range of - there might be a range of
43 health practitioners that are involved in the care, so that
44 could be occupational therapist, podiatry, general
45 practice, oral health.

46
47 But then there might also be some, you know, social

1 providers as well; so we might be linking them into a
2 housing - social housing provider. We might be linking
3 them into drug and alcohol counselling services, so
4 counselling would be another. So, depending on what the
5 need of the client is, we bring in the right care team
6 around that client.

7
8 MR O'MEARA: Thank you. You've mentioned both the system
9 of referral within your organisation but also referral out
10 of the organisation, perhaps to social providers not
11 necessarily health providers, and there's already been
12 mention made in some of the evidence to warm referral. Can
13 you explain how the system of referral within your
14 organisation and, for that matter, outside works?

15
16 MS BARTHOLOMEUSZ: Yeah. So, we know that for this client
17 group to access the care that they need, ideally you want
18 all of those services that are required in the same
19 location and the ability really for that client, when
20 they're attending to see as many of those service providers
21 at the same time.

22
23 We know that, if we ask clients to attend a different
24 provider, a different site on a different day, the
25 likelihood of that client being able to make that
26 commitment to attend that appointment is very, very low.
27 So, what we do is, through our case manager or case
28 coordinator is actually, within and external to the
29 organisation, is have that individual accompany the client
30 to that appointment, make the introduction.

31
32 Often within our organisation - so, if I use the
33 Central City Homelessness Mental Health Outreach Team at
34 Central City where we don't have public oral health
35 services, we do have team members from our public oral
36 health clinic coming to the central city location and doing
37 oral health screening.

38
39 So, there's an opportunity for the client, together
40 with their case manager or care coordinator to meet the
41 oral health clinician, the screening occurs, they're
42 establishing that relationship with that provider, and then
43 an appointment would be made and the care coordinator may
44 accompany that client to that dental appointment. That's
45 just an example of how that works.

46
47 So, we absolutely work on building a relationship,

1 establishing trust between the clinician and the client,
2 but recognising that, you know, the client requires
3 services outside of cohealth, seek to provide a similar
4 service externally as well, so introducing the client to
5 the new provider and that's a warm referral.

6
7 The evidence demonstrates, or our data demonstrates,
8 that the client is much more likely to maintain or keep
9 that appointment if those services, or wrap-around support,
10 is provided to the client in attending another appointment
11 elsewhere.

12
13 MR O'MEARA: Thank you. Dr Deveny, thank you, I've been
14 with Associate Professor Moylan now and Ms Bartholomeusz
15 for quite a while, so thank you for waiting so patiently,
16 but I'd like to ask you to address a couple of things for
17 the Commissioner's benefit if you could. One concerns the
18 system of referrals and funding of referral and the
19 difficulties that can arise there, and you've got some
20 perspectives on that.

21
22 And also, so far as a component of care is concerned
23 or a prospective on care is concerned, the problem of
24 alcohol and drugs and the workforce there and the stigma
25 attached to it and the need to build capacity in that
26 particular area, it being a very important area of
27 treatment for a lot of clients.

28
29 DR DEVENY: Certainly, Stephen. I want to reassure you
30 that, when everyone else is speaking I'm feeling quite
31 relaxed, so there's no hurry to come back to me, first of
32 all.

33
34 So, in terms of referral, from a primary health
35 network perspective we're really thinking about our stepped
36 care model. This comes from the work that was undertaken
37 several years ago by the National Mental Health Commission
38 who established this notion of stepped care.

39
40 So, when a client - and I should point out that a
41 person themselves can ring our access and referral line, so
42 can their family, and so can their GP or another healthcare
43 professional, so we want to make that beginning point very
44 open. Anyone can seek help.

45
46 From that point our clinicians and our other telephone
47 staff - we have both kinds of clinical and non-clinical

1 people in our access and referral team - will find out from
2 that person what it is they think they need. Now,
3 sometimes they'll already know because they have a mental
4 health treatment plan or they have an agreement with
5 somebody as to the next steps. Sometimes they'll need to
6 have some assessment done.

7
8 So, in the case where it's clear what the next steps
9 are for this person our team will refer them into one of
10 our providers. Having visibility across all of the
11 services we provide means we understand what the wait times
12 are, we know what all the services certainly within our own
13 system have the capacity to do, and then we can put the
14 person to the service that will best meet their individual
15 needs. And sometimes this might mean saying to them,
16 "There are a couple of options: you could come to this
17 service close to your home next week, or there's a service
18 tomorrow that can see you but it's a further distance", and
19 as Nicole said, we think about, well, is that going to work
20 for them? Their family might say we can take them, the
21 provider might have brokerage funding where you can provide
22 them with a Uber. So, I think it's really important, I
23 agree with Nicole, making sure people can get there is
24 important.

25
26 Once they're there, then the referral is within our
27 system. So, we have a policy that you tell your story
28 once, clients consent to that. So, if somebody's in say
29 our moderate services and they have an exacerbation, they
30 don't have to go out of our service system; our provider
31 will have a conversation with them, agree that their needs
32 are greater than the service that they're in currently, and
33 then we'll move them out to another service, so they don't
34 have to undertake any more eligibility kind of hurdles, and
35 in some cases it's the same service provider.

36
37 So, we also have services running a range of things,
38 much like cohealth does. So, someone might be literally
39 walking into a different room, in some cases they may even
40 have the same clinician depending on what the program
41 actually is. Then we hope they may recover and then move
42 them down in acuity, but if they need more service they can
43 move back up again.

44
45 So, the benefit of stepped care, or one of the
46 benefits, is that providing that navigation for clients,
47 and because our data systems sit behind that, that means

1 that information about the client can move from provider to
2 provider as appropriate to prevent them feeling like they
3 have to go out and in again to service.

4
5 In relation to services that we don't fund, and there
6 are lots of those, again, as both really Stephen and Nicole
7 have described, we do try to link them through to those
8 services as best we can. The digital - and the Chair
9 mentioned that in her opening statement, that the digital
10 is really important.

11
12 So, one of the things we see that's happening now is
13 that, if we want to do a warm referral - let's imagine
14 Steve is looking after me, thanks Steve - and he decides I
15 really need to see Alex, he'll set up a Zoom meeting with
16 Alex and Steve and myself, so that's a warm referral now.
17 He'll have a chat to me, Alex will have a chat, we'll agree
18 what Alex might be doing that might be different to what
19 Steve was doing or in parallel with the work I'm doing with
20 Steve, and he can then just leave the chat and suddenly
21 Alex and I are having an appointment.

22
23 So, that's a really good example of what a warm
24 referral can look like leveraging off technology and, for
25 those clients where that's a possibility, that's a terrific
26 outcome.

27
28 So, we would work, again, with our providers that are
29 inside our services through our stepped care model, so our
30 component parts, if you like, are all packed into that
31 model. And then we would outreach out to other service
32 providers, and again, both in the social care, they might
33 be disability services, they may be other health services,
34 with that same kind of referral mechanism that's been
35 described as best we can. Because that navigation piece,
36 which I know you're all acutely aware of, is probably the
37 trickiest piece for clients and their families.

38
39 MR O'MEARA: The referral that you've referred to via
40 Zoom: one of the issues with referral sometimes seems to be
41 funding; how is that funded?

42
43 DR DEVENY: So, in the case of our services, our services
44 are funded for also providing that referral, that's part of
45 what we fund them for because they're working within a
46 stepped care model. We expect them to refer people both
47 across our services and outside, and that's some of the

1 data we collect from them. We actually want to see that
2 patients are being stepped down, and we should see the
3 occasional one also being stepped up, and they should also
4 be able to tell us they have new clients coming into their
5 service; they're not, if you like, recycling existing
6 clients through every possible funding stream. We want to
7 see new clients coming in, we want to see clients going and
8 we want to see referrals to other agencies and we collect
9 that data from them so that we can see that those referrals
10 are actually occurring at a rate for which we consider is
11 acceptable.

12
13 MR O'MEARA: Thank you. You've referred to the system as
14 stepped care, I wonder if you could address or identify
15 what those steps are, whether they've been changed over
16 time; if so how they came to be changed, and why they came
17 to be changed.

18
19 DR DEVENY: Certainly, Stephen. I also know that - I
20 haven't yet spoken about drug and alcohol but that could
21 take two hours, so let's do stepped care first.

22
23 MR O'MEARA: I'll give you four minutes, how about that?

24
25 DR DEVENY: I've got three minutes on my egg timer so
26 we'll see how we go. For - oh, I've just lost my train of
27 thought, you'll have to --

28
29 MR O'MEARA: Stepped care.

30
31 DR DEVENY: Great. Yes, this comes from the work of the
32 Mental Health Commission, and the notion is that people
33 with mental illness might require more or less services at
34 any given time but they shouldn't feel like they have to
35 move out and around a system. And we've talked about this
36 notion of no wrong door, and now people talking about,
37 there are so many doors they're not sure which ones to go
38 in and out. They're no longer perhaps concerned they're
39 not welcome, it's more about knowing which door will give
40 me what I need, a bit like pick-a-box.

41
42 In relation to the stepped care model, when someone
43 comes through our access and referral system which I've
44 described and they go into a service, they could go into a
45 very high acuity service, we call this our integrated care
46 service, where there will be a multidisciplinary team, and
47 these are people who don't need acute care but they're not

1 far off; they need a lot of support, they may need both
2 psychosocial support as well as clinical support, they may
3 need also referral to other services, could be kind of
4 child protection, family violence, all kinds of issues for
5 those clients.

6
7 The next step down originally was moderate, so this is
8 people who might have high prevalence disorders, perhaps
9 some anxiety and depression, for example, and these people
10 would be in a service environment where there's probably
11 not as many disciplines working with them; may have a
12 mental health nurse, a psychologist, something like that.
13 They may not need as many episodes of care.

14
15 Then the lower step was mild, so these are people who
16 are, you know, fairly well, may benefit from working with
17 an allied health practitioner and/or with their GP.

18
19 So we started with three steps. What we discovered
20 over the journey was that three steps is not enough,
21 because the step between each step is sometimes too large
22 for clients, and the one that's often spoken about is the
23 step between acute care and the first step at our level, so
24 our most acute care.

25
26 When clients are in Steve's wonderful services in his
27 ICU, they do really have everything looked after: their
28 meals are coming, they've got a bed, they've got
29 everything. When they move out back into society, into
30 community, sometimes just those social needs are quite
31 overwhelming, and then they may also have some of their
32 clinical issues triggered by being back in that
33 environment. So, we've found increasingly that that gap
34 between being in an acute service and then being in a
35 community-based service, people need a lot of support to
36 get from one step to the other, so we've built in through
37 the development of additional programs or providing
38 capacity to some existing programs, extra steps.

39
40 Then we've also built extra steps or programs or, you
41 know, capacity, if you like, between that high acuity and
42 the moderate and so on. So, I suppose what we've learnt is
43 that the notion of steps is a good notion, conceptually
44 it's great. But as implemented in practice, we needed more
45 steps.

46
47 We've also broadened steps, so this is where something

1 like drug and alcohol comes in. So, we know that people
2 will have a variety of comorbidities. Maybe they have an
3 intellectual disability, perhaps they'll have a drug and
4 alcohol issue, perhaps there are other social issues that
5 they have that need to be addressed, so we understand that,
6 when people come into our services they don't want to have
7 to go out for their others services. So, for example, out
8 for the drug and alcohol service. So, our access and
9 referral team refers people into both our mental health and
10 drug and alcohol services. And we've built the steps more
11 broadly, so we might have a provider that also provides,
12 for example, a service particularly for people who don't
13 speak English as a first language, or they might provide a
14 service that's culturally appropriate for Aboriginal and
15 Torres Strait Islander people, or we might have services
16 particularly for people who are experiencing family
17 violence.

18
19 It might also be by cohort, so we might have service
20 components that relate particularly to young people or to
21 young mums or to older people, so there are a range of
22 services. But as we understand the population health need
23 and as we iterate the model over time, relying both on the
24 data we get from our clients as well as from our population
25 health data, we are wanting to expand or broaden those
26 steps so that, if people that have a moderate level of
27 acuity, there are a range of things that they can do within
28 our model without having to kind of order aside from
29 somewhere else; we want them to get that all from us as
30 best we can, recognising that we don't hold all the
31 funding.

32
33 So, the challenge for us is always when our capacity
34 means that we cannot provide that amount of service to that
35 amount of clients, then we do have to have people moving
36 out of our services into other services and we do that as
37 much as we can.

38
39 We try where we can to co-locate services with other
40 providers and people who are accessing other funding
41 services. So, for example, we fund community health
42 services as Nicole mentions happens in the west. So, for a
43 client, they might be receiving a service provided by the
44 PHN, by the State Government, by the Federal Government,
45 but what we don't want is a client to feel like they have
46 to go in and out of service.

1 The example often I think of here is Amazon, not that
2 I'm a big fan of Amazon; or, I am a fan of Etsy if you've
3 ever been on that site, or Steam if you're into gaming,
4 where you feel like you're having one experience of retail
5 therapy because you go to one place and then with PayPal
6 you pay once, but actually there are lots of individual,
7 small businesses that sit behind that.

8
9 So, what I think the stepped care model does is
10 exactly that; it gives the client the sense that they're
11 experiencing one care, where in fact behind that there
12 might be 10 funding deeds and 20 different providers
13 finding different models for different people, and I think
14 that's what consumers need, and I think that's what they
15 want. They want to have that same experience of care that
16 they can get outside the health system. I think that's
17 their current expectation and I think that's what we should
18 aim for.

19
20 MR O'MEARA: Thank you. Some other witnesses have drawn
21 distinctions between stepped care on the one hand and
22 staged care on the other, and often the adherents to the
23 system of staged care are quite critical of the stepped
24 care model. Do you have a perspective on the competitive
25 benefits of those two systems, if any, and a comment for
26 the Commissioners concerning what those benefits might or
27 might not be as the case may be between them?

28
29 DR DEVENY: Thank you, Stephen. I'd be keen to understand
30 what they mean by "staged care" and how that differs from
31 stepped care?

32
33 MR O'MEARA: It seems to relate to, and I might not be the
34 right person to answer this, but it seems to relate to the
35 concept that mental illness, just like cancer, can have
36 identifiable stages. And stepped care can be a bit too
37 rigid and a bit too linear in caring for people and not
38 recognising the fact that their illness can have a
39 recognised pattern.

40
41 DR DEVENY: You see, I think this is a really core issue.
42 I don't see stepped care as being rigid, certainly not in
43 the way that we provide it and as I've described it. It's
44 very much about understanding what the client needs and
45 getting them the level of care they need at the right time.
46 And so, if somebody's journey through mental illness means
47 they require more or less care, stepped care facilitates

1 that. It's not rigid in the sense that you've described,
2 that you're in moderate and that's where you stay. The
3 whole purpose of it is to ensure the person gets the right
4 care. So, if they now are at a point in their journey
5 where they need less care, fantastic; if they need more
6 care, well, we can help them with that too.

7
8 I don't see - the fluid nature of it and the fact that
9 there's a continuity of information as well as a continuity
10 of care through both the intake services that are run as
11 well as the way that the system itself is set up to
12 encourage integration, I think, actually reduces the chance
13 that they'll be stuck somewhere.

14
15 MR O'MEARA: Thank you. Associate Professor Moylan,
16 you've expressed the view that it's important not to be too
17 linear about the way in which you think about care, and I
18 might ask you about that just before we take a break, for
19 everybody's comfort we'll take a 5 minute break after
20 you've had the opportunity to address that issue, if
21 possible.

22
23 ASSOCIATE PROFESSOR MOYLAN: So, not too linear. I
24 suppose the thing that we all recognise is that we try and
25 create models for systems, but people don't fit into models
26 per se. And when we actually sit and look at an individual
27 consumer's needs, they will have a vast variety of
28 different needs that cut across different kinds of acuties
29 or levels.

30
31 Some people have very severe illness characteristics
32 of a treatable mental disorder and have very little or
33 otherwise psychosocial or other needs. Where the flip
34 reverses completely as well - happens as well, and I think
35 it just speaks to the need for, whilst models are very
36 important to set up frameworks for organisations and things
37 to govern systems, it speaks to the need to allow the
38 flexibility underneath those frameworks for localised
39 systems and providers to adapt the way they provide care to
40 their local communities and the individual consumers who
41 are part of that.

42
43 So, I wouldn't want us to go down a line where we say
44 we are adherent to this type of system, and then in this
45 bucket if you meet these criteria then you get X and if you
46 meet these criteria you get Y, because that just doesn't
47 match reality. And it also doesn't match reality for need

1 and it also doesn't match reality for desire, or want, or
2 request, or consumer interest, so I think we have to
3 respect that.

4
5 I suppose when I was talking about linearity, I think
6 it just speaks to that, things don't just happen in a
7 system where someone becomes mildly unwell, then they
8 become moderately unwell, then they become severely unwell,
9 and then they drop back to moderately like that - it
10 doesn't work that way.

11
12 When I spoke before about the nature of our system, we
13 have a strong role in providing complex, severe,
14 rehabilitative care for people experiencing those
15 situations over an extended period of time, but we also
16 recognise we have a role to provide for people,
17 irrespective of diagnosis or cause, to be able to provide a
18 function around acute crisis, intervention and support.

19
20 I think in a way, if we structured up an entire system
21 which sort of said, you know, you had to be looked after by
22 our system, then actually people bounce in and out of that
23 very rapidly depending on needs which aren't related to
24 their healthcare, it's related to other factors in their
25 lives, and we could miss something in that nuance.

26
27 I suppose one other thing I wanted to say Stephen is,
28 it just goes right back to the physical health needs and
29 it's just important, you know, to represent here, there is
30 very good strong scientific and biological evidence around
31 the inter-relationship between the expression of mental
32 health distress and mental health symptoms and physical
33 health conditions. This has been - you know, my PhD is in
34 interrelationship between early life exposure to smoking
35 and subsequent expression of anxiety in children,
36 adolescents and adults. And there are dose relationships
37 in these factors.

38
39 So I think it's really important to note that, whilst
40 we kind of say it is important, you know, from I think a
41 societal perspective; of course people with mental health
42 issues should have their physical health issues looked
43 after et cetera, and sadly there's absolutely no doubt
44 across the entire health spectrum people with mental health
45 disorders get poorer quality medical care, absolutely no
46 doubt about that, and I see that every day in hospitals and
47 emergency departments across the board.

1
2 But actually, we are missing a very, very substantial
3 opportunity to improve someone's mental health care status
4 by improving their entire health status, and if the
5 Commission has a leverage point around enhancing that, I
6 think that we'll see benefits, not only for people's
7 physical health or their mental health, but actually our
8 entire society as well.
9

10 MR O'MEARA: Thank you. We might take a break in two
11 minutes. Dr Deveny, just before we go - I said we were
12 going to finish after Associate Professor Moylan but I lied
13 - Dr Deveny, before we take our break, you've referred to
14 the model of stepped care and it seems implicit from your
15 witness statement in some of the things that you've said
16 already today that that model can operate and can be
17 adjusted because of the, if you like, data and prevalence
18 analysis that you've undertaken (indistinct) services you
19 actually have in your region and what the demographic
20 characteristics of your region are. Is that correct?
21

22 DR DEVENY: Yes, that's right. So, we regularly evaluate
23 our programs. We also run - I think I mentioned - in a
24 community of practice. So, we're having that conversation
25 that I mentioned earlier, the third point I made about what
26 good looks like, with clinicians through our communities of
27 practice with clients through their PREMS and PROMS and
28 then understanding what needs to shift. We're not shy of
29 changing things because we're working with data. So, we
30 have evidence, we see there's a need for a change, and so
31 then we make that change.
32

33 MR O'MEARA: Thank you. At that point I might let
34 everybody have a five minute break, and I'll see you all at
35 20 past.
36

37 **SHORT ADJOURNMENT**
38

39 MR O'MEARA: Are we all ready to go? Excellent, I can see
40 a lot of nodding. One of the issues that we discussed in
41 the conclave last week which was a matter of some interest,
42 was the role of outreach.
43

44 Associate Professor Moylan, you had some views on the
45 topic of outreach and I might let you start on the topic,
46 if that's possible.
47

1 ASSOCIATE PROFESSOR MOYLAN: Thank you for the prompt.
2 I'll think about exactly what my views were at the time.
3 Look, I think the way I simply see it is that the ideal
4 mechanism for people - so there's two forms of outreach and
5 I think there's a language issue here that we need to get
6 really correct, because when I refer to outreach I think
7 that my internal definition may differ from others in terms
8 of how outreach is characterised, so perhaps I'll describe
9 my understanding of both and I know Nicole might be able to
10 talk about outreach from a cohealth perspective.

11
12 But that's an individual difference between providing
13 services in a consumer's home or if they're homelessness in
14 a community-based setting et cetera, so moving out of an
15 office to go and provide services, which I think
16 qualitatively differs from acute crisis based responses in
17 after hours and community settings, and so, I'll probably
18 operate on the latter.

19
20 We absolutely know that the last - you know, it is
21 preferable to be able to provide care for a consumer in
22 their position where they are at the time, noting that
23 there will be people who need to attend hospital based care
24 or other based care depending on the circumstances that
25 they're in at this time. Clearly, if I was in distress
26 with my family at home it would be really preferable for me
27 to not have to move that family member to an Emergency
28 Department or to have an ambulance come and do the same,
29 but to have skilled clinicians be able to come out to my
30 home in a responsive fashion, meet with a family member or
31 myself, talk about what needs to happen and basically
32 coordinate the next steps from there.

33
34 So, from an area-based mental health perspective I
35 think it is vital, talking about that initial a diagnostic
36 response we have, this safety response around risk and
37 acuity at the time, to be able to provide that outreach
38 into consumers' homes.

39
40 One of the opportunities I think that we have, and
41 down here in Barwon have been utilised over time, is our
42 inter-relationship with emergency-based services.

43
44 So we run two programs, one which is established
45 across the state which is the PACER based program with
46 police, and the second is a new one we started last year
47 which is a similar service with Ambulance.

1
2 Essentially the way this structures up is that we
3 know across the Geelong region every day there's about 15
4 calls to Triple Zero for ambulance responses predominantly
5 relating to a mental health condition. The partnership
6 that we've formed is essentially that we have a shift that
7 runs with Ambulance Victoria where a mental health
8 clinician and a skilled paramedic operate together and it
9 can be a call to respond to that call in the person's home
10 or in a particular setting as a second call.

11
12 What we've seen from that is that we can divert
13 approximately two-thirds of people away from
14 emergency-based care where they otherwise would have been
15 brought, so that sort of splits up into either directed
16 admission to an inpatient unit or continued referral or
17 care in a community-based setting, so keeping people at
18 home rather than transporting them in.

19
20 One of the things that I've noted across the state,
21 and you know I'm sure you've heard other testimony about
22 this, is that, we've gone from this notion of having CAT
23 [Crisis Assessment Treatment Teams] based teams or
24 community outreach based teams and then they've gone out of
25 favour a little bit in terms of a model. I think you're
26 probably hearing about how important a function they do
27 serve in being able to provide these community-based acute
28 responses with the ultimate goal of keeping people out of
29 an Emergency Department. Because I know, once a person
30 comes into an Emergency Department, they are significantly
31 at greater risk of receiving a trauma event being at
32 hospital.

33
34 We know from broad things, you are far more likely to
35 have an adverse outcome if you end up in a hospital in
36 general, and for people with mental health distress
37 Emergency Departments are not appropriately set up to be
38 able to care or provide for that. There are some obvious
39 things that are being done to try and improve that.

40
41 So, when I refer to community-based outreach care I
42 really refer to that ability to say, you know, receive a
43 phone call from a GP, from a family member, from an
44 individual consumer who says, I'm really distressed, I need
45 a response, and our ability to go there and meet with the
46 person. And I think there's a physical based element to
47 that and a telehealth-based element to that that can be

1 leveraged in a new, you know, advanced model of care.

2

3 MR O'MEARA: The kind of outreach provided by Barwon
4 Health is one thing; what about your views about some of
5 the other outreach functions out there? I think in the
6 conclave you made mention of headspace, for example.

7

8 ASSOCIATE PROFESSOR MOYLAN: I just think that there's a
9 differentiation between the two. So, I think that it's a
10 definitional issue and you would have to ask headspace,
11 et cetera, what they mean. But services talk about "we
12 provide outreach services". I don't think they necessarily
13 mean outreach acute service responses. A significant
14 proportion of the community-based mental healthcare we
15 provide is done out of office-based care, so it's done in
16 people's homes, in shopping centres, at cafés - you know,
17 this is pre-Covid of course - and, you know, we hope to get
18 back to that because we understand, for people with the
19 type of acuity or complexity that we're working with daily,
20 office-based care often isn't the best, and having an
21 understanding of the person's living conditions and their
22 community is actually a really vital component of the care.

23

24 So, that's what I mean when I talk about outreach, and
25 I think when others talk about sort of outreach they may
26 mean something different, so that's - and I think probably
27 Nicole's probably in a good position because I think in our
28 conclave we bounced off each other with that.

29

30 MR O'MEARA: Let's bounce the ball in Ms Bartholomeusz'
31 direction. Ms Bartholomeusz, cohealth provides outreach,
32 what definitionally do you mean by that and what does it
33 do?

34

35 MS BARTHOLOMEUSZ: So again, we - yes, we do provide
36 outreach and outreach I suppose on a continuum, so there is
37 a range, I suppose, when you think about the outreach work
38 that we do.

39

40 So firstly, I'd say that we provide what we call
41 assertive outreach, so that's actually having skilled
42 workers going and finding, for want of a better word,
43 people who might need support, health and wellbeing
44 support.

45

46 So, for instance, our specialist healthcare team that
47 provides care to the homelessness population will regularly

1 go out, leave our clinic, walk around and engage with
2 people who are sleeping rough, and that's really by way of
3 actually connecting with people, understanding - you know,
4 building those relationships, building that connection,
5 seeing what support we might be able to provide to the
6 individual that's sleeping rough.

7
8 And that goes for a range of our sort of vulnerable
9 community, so it might be the homeless population, it might
10 be our injecting drug user population, so assertive
11 outreach to those communities where those communities
12 regularly spend time and connecting, building
13 relationships, seeing whether there's support services that
14 we can link them into.

15
16 Then I suppose the other part of the outreach work
17 that we do which is closer to Steve's definition, is
18 actually providing or taking the care from our clinics to
19 people's places and spaces. So, whether that's at a
20 community centre, whether that's in somebody's home,
21 whether it's taking care to the supported residential
22 facility where they're currently living. It's about
23 reducing those barriers of access that people have into our
24 clinics and taking care to them when it's, you know, safe
25 and able to do so.

26
27 I mean, not all care can be provided in people's
28 places and spaces, but you know, at times alternatives to
29 clinic - there are alternatives to clinic-based care and at
30 times you can actually achieve equal or just as good
31 outcomes by taking the care to where the individual is.
32 So, it's really about reducing those - firstly, increasing
33 access to services by going out and assertively outreaching
34 and connecting to people, but then it's also about looking
35 at what are the services or what is the care that's
36 required by this individual and taking that care to the
37 person if they can't actually come in to receive care in a
38 clinic.

39
40 MR O'MEARA: Thank you. Dr Deveny, you've described
41 outreach as, from your perspective, finding new clients.
42 Can you speak to your own observations and experience of
43 outreach?

44
45 DR DEVENY: Certainly. I think this is a really important
46 component part of community-based mental health and I would
47 agree with Steve that people who have high needs absolutely

1 need to have that provided through the lens of an acute
2 service so that can be done appropriately.
3

4 My experience in the work that we do is more about
5 making sure that those steps in our stepped care model,
6 there's the ability for people to see people in their usual
7 places and spaces much as has been described by Nicole, and
8 to be aware that for some people the locations that we
9 provide care in are actually a barrier.

10
11 So, I would use headspace as an example here. We fund
12 five headspace services, and speaking to young people, you
13 know, several years ago, it was clear to me that
14 middle-aged, perhaps white young people experiencing
15 mild-to-moderate mental health issues felt more comfortable
16 walking into the door of a headspace than somebody who was
17 living rough, was traumatised. They made the comment to me
18 that it was too clean; that, you know, daily life wasn't
19 like inside that kind of shiny green headspace.
20

21 Nevertheless, headspace may have had the services they
22 wanted, so it's about building the trust, and Nicole spoke
23 a little bit about that too, so doing a bit of case
24 finding, you might call it, where you go out, you meet
25 people and then you identify the services they need and you
26 build the trust and hopefully then you can bring them into
27 the service. We've seen this occur across a range of our
28 services: again, homelessness services that we fund, drug
29 and alcohol services, psychosocial services.
30

31 I'm smiling because there was a gentleman who we
32 provided services to in our Partners in Recovery Program,
33 which is a psychosocial program, and he lived in a park and
34 the worker would have to beep his horn in a certain way for
35 the guy to come out and then we'd be able to provide him
36 with services. So, for some people building that
37 relationship would be critical.
38

39 Again I think of a Sacred Heart Mission, we provided
40 them with some funding and they spoke about the
41 relationship they build through the services they provide
42 during meal times, building the relationship to a point
43 where someone was willing to seek help for a problem that
44 they might not have done without that trust. So, for me
45 sometimes the location is not appealing for clients, and
46 sometimes it's because of where the client's at. There's a
47 lot of trust and relationship needs to be built before

1 someone will consider accessing a service and I think
2 that's where outreach is really important and, you know,
3 one of those important component parts.

4
5 MR O'MEARA: Thank you. While I've still got you, all
6 three witnesses have spoken of the importance of outreach
7 in different ways or from different perspectives. An
8 outreach is, itself, a concept which has had some years of
9 history. Is there a way or does it need to be looked at
10 differently in 2020 and beyond to a way that it was looked
11 at in the 1990s? Does it look different, does it function
12 differently, or is it really just the same?

13
14 DR DEVENY: I think that we describe it differently. So,
15 we talk about in-reach, we talk about outreach, we talk
16 about assertive outreach, we have a whole lot of words for
17 it now because I think it's grown over time and there are
18 different models for different communities that you need to
19 apply.

20
21 I think the other comment I'd make here, Stephen,
22 relates to really using the money better. A lot of
23 outreach now can be done digitally and that can be very
24 efficient. So, if you can outreach to clients, as many
25 people have done over the last few months, by WhatsApp or
26 Messenger or telephone, that is generally cheaper than a
27 face-to-face meeting, because there are no travel and other
28 costs, and for some clients it's preferable.

29
30 For most people a mix of both face-to-face and other
31 digitally mediated conversation will work, and then there
32 are some people that really only the face-to-face is where
33 they'll get the most benefit. So, I think if we talk about
34 wanting to spend the money better and we're talking about
35 how we outreach to people where they're at, we really
36 should think about how we can do that using the digital,
37 because every dollar we free up is a dollar we can spend on
38 people who need more intensive services. And that's what
39 the community expects I think, they expect us to ensure
40 that their money is well spent.

41
42 MR O'MEARA: Thank you. Does it follow from what you've
43 said about outreach and the importance of approaching it in
44 an open-minded way with potentially different channels of
45 engagement with the clients, if you like, digital and
46 other, in a modern idea of what that outreach can look
47 like, that that applies equally to what community-based

1 mental healthcare can look like. So, the way in which it
2 could be established in one location might be different and
3 with a different lead agency to how it might be established
4 in another. Is that something you've given thought to and
5 am I right to suggest that to you?

6
7 DR DEVENY: Yes, Stephen, I think it's a really core
8 principle. We're fairly urban - I mean, Geelong's really
9 urban, but particularly in more rural areas the tyranny of
10 distance really impacts on access. If somebody can be on a
11 phone or on a video and getting help quickly, that's much
12 more beneficial.

13
14 We've seen it occur over time again in other
15 disciplines. I think of cancer in particular where a lot
16 of work's done in that area; ophthalmology does a lot of
17 work there too. And there are other disciplines also that
18 have taken this up, this hybrid model where, when we need
19 to, when it's most efficient and most needed, we do it
20 face-to-face, and when we don't need to and there's no
21 driver for that, the conversations can be mediated in a
22 range of different ways.

23
24 I think that is really important for us to think about
25 into the future and not be stuck with this idea of in the
26 office, one clinician versus one patient, but rather much
27 more a multidisciplinary team interacting with a person in
28 a variety of ways, which might include in their place, you
29 know, their home or wherever they happen to be, their work,
30 as well as also in a clinical environment.

31
32 MR O'MEARA: Thank you. One last question: you've talked
33 about mapping the resources in the system and earlier today
34 you talked about the importance of, not only understanding
35 what furniture there is within the system but getting it to
36 work together properly.

37
38 Does it follow from that evidence that you've given
39 that, in approaching how one comes to make community-based
40 mental health care operate that, if you like, the lead
41 agency in administering a community healthcare - I might
42 not be putting this in the right language, but you might
43 well do better than me - administering how that works in
44 one particular region might fall, for example, to something
45 controlled by your PHN, but on the other hand in a
46 different location because historically there's been
47 another piece of furniture there which is State funded, the

1 lead agency should then be the State; and what the burden
2 of your evidence is, you don't need to, if you like,
3 demolish all the infrastructure and start again because,
4 after all, workforce is attached to the infrastructure,
5 it's about appreciating what infrastructure there is and
6 then identifying where the lead agencies are around the
7 State within the regions. I wonder if I can get you to
8 speak to that.

9
10 DR DEVENY: Yeah, so I come back to my first point that I
11 made earlier which is about the efficient use of tax payer
12 money. So, if we already have existing facilities and
13 infrastructure that can do that work, I don't understand
14 the need to create a new version.

15
16 I would say, in the example of Primary Health
17 Networks, all of the things that we've talked about needing
18 to do: better spending the money, making sure we have all
19 the right component parts, having a clear view of what good
20 practice is going to look like for us, collecting and using
21 the evidence really effectively, that's what we do and if
22 that's what's needed to lead the future revolution of
23 community-based health services, then PHNs are in a prime
24 position to deliver that.

25
26 But your comment is, well, does it have to be a PHN?
27 And my answer would be, I'm agnostic to what you call the
28 agency, though clearly I can see that we have the capacity
29 to do that, but what's really important is those
30 components, that we could make sure that we are efficiently
31 using public money, that we have the right pieces and so
32 on, that's what's important, and I think that's my day job,
33 so, I just say, well, that's something we can do, and we
34 can do it well.

35
36 MR O'MEARA: Thank you. I said that I had one last
37 question and I was wrong, I've in fact got one last
38 question beyond the one last question, and that is, when we
39 talk about the efficient use of tax payer money, you say in
40 your statement that you don't yourself engage in, if you
41 like, consortia because there needs to be ultimate
42 responsibility for knowing who's spending the money and so
43 on. I wonder if you can speak to that before I go to
44 Ms Bartholomeusz with a different perspective.

45
46 DR DEVENY: Certainly. So, through our contracts with our
47 funder there are quite a range of matters that we need to

1 provide assurance that will be delivered on, so compliance,
2 if you like.

3
4 When we're funding an agency those contracts will be
5 back-to-back. So, whoever we're funding will also need to
6 ensure compliance with, and you've all seen them, very
7 thick contracts. So, for us it has to be one organisation
8 that's accountable to deliver those outcomes and to meet
9 the compliance requirements.

10
11 That one agency may then partner, subcontract or have
12 some other mechanism for drawing on the local resources and
13 expertise to deliver on that, but ultimately one
14 organisation is responsible, in the same way that the PHN
15 does that. The Commonwealth gives us a range of funding
16 for different pieces of work and then asks us more broadly
17 to be responsible for the population health needs of a
18 community, and so, we make sure that as we do our work,
19 that we retain that accountability and ultimately it's our
20 job to make sure we improve the outcomes in the areas that
21 we're funded to deliver.

22
23 I think it's very difficult, having worked in
24 consortia, to have that same level of accountability and
25 efficiency when 10 people think they're responsible for
26 doing something. I know in my home, if I ask my children
27 to do the dishes they never get done. If I ask a specific
28 child to do the dishes, I have more of a chance.

29
30 MR O'MEARA: Thank you. Ms Bartholomeusz, you've
31 experience of consortia funding, if you like, and you've
32 also had experiences of accountabilities in your
33 circumstances and, as I identified and you identified at
34 the outset, your organisation has multiple sources of
35 funding, I wonder if you can address this topic for the
36 Commissioners.

37
38 MS BARTHOLOMEUSZ: Thanks, Stephen. So, that's right,
39 multiple sources of funding and if I can talk to one
40 example which demonstrates the work that we're doing but
41 also I guess the complexity that service provider
42 organisations face with multiple sources of funding.

43
44 So, we have an alcohol and other drug services which
45 ranges from education, harm reduction, to treatment
46 services. It's a relatively small sum of money that we
47 receive from State Government, but it comes to us in 22

1 different line items or funding streams, each with
2 different reporting and compliance requirements attached to
3 it.
4

5 Most of our funding is - the reporting for our
6 funding, is activity or output based. So, we're counting
7 number of people seen, number of hours of service provided.
8 The funding isn't attached or aligned to outcomes.
9

10 So, as part of cohealth's work we're really seeking to
11 transform the way we deliver services so that our services
12 deliver outcomes and are impactful for the communities that
13 we work with.
14

15 We've taken on a piece of work within our alcohol and
16 other drug services to co-design what a service might look
17 like that would meet the needs of the clients that we work
18 with; evidence-based, so looking at the current evidence,
19 looking at contemporary practice, understanding what the
20 outcomes and experiences are that our clients seek, and
21 then working with State Government to actually turn those
22 funding streams into a single funding line which has
23 targets and key performance indicators attached to it that
24 are based on the outcomes that we deliver.
25

26 It's a fantastic piece of work, it's innovative, it's
27 new and it's, I think, an excellent approach that could be
28 taken right across the health system, or the primary care
29 system really, in terms of both physical and mental health
30 care delivery.
31

32 Can I just come back to you, Stephen, and just ask - I
33 got carried away in my train of thought there - what the
34 rest of the question was?
35

36 MR O'MEARA: No, no, I was asking about your experience of
37 operating or being involved in consortia.
38

39 MS BARTHOLOMEUSZ: Yeah, okay.
40

41 MR O'MEARA: And I also asked about funding, so you've
42 addressed funding.
43

44 MS BARTHOLOMEUSZ: Addressed funding. So, in terms of
45 working in a consortia: I think it's a model that can work
46 very well. You need effective governance systems and
47 structures in place between consortia parties and really

1 strong partnerships; really strong understandings of what
2 people's roles and responsibilities and accountabilities
3 are, what their expectations for delivery are, and clear
4 leadership.

5
6 And I think, you know, we seek to work in that way
7 because there are many parts of the health system that need
8 to be involved in an individual's care. So, we talk about
9 putting services around a common client, so many of our
10 clients that we see are also accessing other services. You
11 know, they're attending services at the Royal Melbourne
12 Hospital, they're - we're not, you know, the only service
13 provider in the system, there are many other service
14 providers and it's about, you know, our clients are the
15 same as the community health centre's clients next door,
16 they're the same as the hospital's clients, and it's about
17 bringing all of those services together around the common
18 client.

19
20 And so, a consortia model is an effective way to
21 structure that arrangement with funding coming into
22 consortia to provide those services effectively, but there
23 needs to be a clear governance model sitting around that
24 consortia, clear accountabilities, responsibilities, roles,
25 leadership, et cetera, for it to be effective.

26
27 So, our homeless outreach mental health service is an
28 example of a consortia where we bring a number of partners
29 together to respond to the mental health issues of people
30 who are homeless. The area mental health services is
31 involved, we have a specialist women's health provider
32 involved also, but cohealth is actually the lead of that
33 consortia.

34
35 We have other consortias we're involved in, we're a
36 partner, we're not the lead, so it's about identifying who
37 might be best placed to be the lead in a particular
38 consortia and it's not always the same provider.

39
40 MR O'MEARA: Dr Deveny's identified the problem of
41 everybody being responsible and nobody being responsible.
42 Is the answer to that in your experience through clear
43 understanding of who the lead agency is, or is it beyond
44 that?

45
46 MS BARTHOLOMEUSZ: No, I think that's a really important
47 element, is having clear leadership or a lead agency that

1 has ultimate responsibility, but also that all partners
2 within that consortia have clear, as clearly outlined and
3 agreed what the roles and responsibilities are, so that
4 everybody is contributing to the leadership of that
5 consortia.

6
7 But I agree, for funding, for reporting, for ensuring
8 you know that compliance requirements are met, for ensuring
9 that accreditation standards are achieved, having clear
10 leadership is very important.

11
12 MR O'MEARA: Does it follow from what you've said - you've
13 referred to the program in which your organisation is the
14 lead agency, is your organisation also involved in other
15 consortia in which you're not the lead agency?

16
17 MS BARTHOLOMEUSZ: Yeah, we are, we are, and in those
18 other situations there may be a - you know, another
19 organisation that is better placed to be lead, and so, it's
20 situational.

21
22 MR O'MEARA: Would you be able to give an example of where
23 that's the case?

24
25 MS BARTHOLOMEUSZ: You might have to come back to me, I
26 might have to think about another example.

27
28 MR O'MEARA: Why don't I go to Associate Professor Moylan.
29 By all means contribute on the topic of leadership and lead
30 agencies if you like, Associate Professor, but I was going
31 to you on the related topic of funding, and you've
32 expressed views on the need to fund outcomes as opposed to
33 throughput, I might just get you to speak to that issue
34 while Ms Bartholomeusz is racking her brain on that other
35 topic.

36
37 ASSOCIATE PROFESSOR MOYLAN: Sure, I feel like I'm coming
38 off a long run here because this is kind of warming up to
39 where we're getting to.

40
41 I think to be honest - so as an area mental health
42 service we receive a whole series of State Government
43 grants and funding lines that come through from the
44 Department of Health and Human Services, and they are the
45 blocks to actually - that are very ill-defined or they're
46 based on input-related factors. So, we'll give you X money
47 and you do X number of contact hours; they're not related

1 to outcome at all.

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And we have over the top of that a statement of priorities for even further key performance indicators of the whole of health service, for mine, can be drastically improved to reflect actually the experience of care for consumers and not just the limited number of bandwidth. That won't be new to any of the Commissioners, I think the way that we're funded does not drive us to a place where we provide actual improved outcomes for consumers, and I think one of the things we have to get our heads around is the experience of care being an integral component to a person's actual ability to reap benefit from that care.

So, I'm a strong proponent that we need to move a funding arrangement away from classic input to an outcome-based system because, how you localise that in a particular area to achieve its outcomes will depend on the local conditions, local providers et cetera.

I also have a view as well, and I think this might be unpopular, but I think there are too many providers in the system, and I think part of that is because of the deep political nature for how funding in mental health services has come up.

So, we are the lead of the local alcohol and drugs consortia of which there are, you know, I think a workable number of organisations involved, although one of the agencies actually dropped out because the funding allocation they received was so small it wasn't even worth their while, and I think that's about four.

I'm aware of other consortia around alcohol and drugs which have, you know, 15-plus providers involved. To me that's ridiculous. I don't know how you can actually design a system to actually achieve the outcomes you want with such a diverse range of things, and I think we have to be, you know, driving around: there needs to be sufficient scale, operational ability to be able to run health services across the region.

I think one of the things we struggle with in mental health is to be able to identify what are actually - going back to Elizabeth's point - what are actually the core components of the service that need to be provided, who has the sufficient scale and expertise to be able to do that,

1 to achieve the outcomes we want to achieve and then have
2 the funding lines actually flow through to do that. There
3 will be a whole series of little providers who have
4 received historical grants for long periods of time which
5 leave them just on the edge of falling over, but just
6 enough to keep going. To me that's not a smart way to
7 operationalise the system.

8
9 So I just go back to this notion that, as a - and I
10 think I'll say something as well in the secrecy of this
11 sort of thing, you know, I get to do that. I think the
12 Department has had a blurred understanding of its role
13 here, the Department of Health and Human Services.

14
15 In my view they're a funder and a policy setter, but
16 at some level they've also wanted to be a service provider
17 and that's sort of come out in small grants and individual
18 lines of things saying, we'll give you this money to do X
19 and it's going to happen, 31 of them across the state are
20 going to occur here or we're going to do this little
21 particular program here. Rather than actually saying from
22 a policy perspective we want you to do X, you know, achieve
23 X outcomes, here's the funding, report on the outcomes and
24 how you've used the funding, and I think there's been a
25 blur of that that's occurred over time particularly in
26 mental health, probably more in mental health than other
27 areas, although I can't speak to that in other areas per se
28 but just by observation of how other areas of the health
29 service runs versus how ours runs.

30
31 MR O'MEARA: Thank you. Dr Deveny - I am going to come to
32 you, Ms Bartholomeusz - if I can just go to Dr Deveny on a
33 matter that Associate Professor Moylan mentioned.

34
35 Dr Deveny, on the topic of outcomes, your PHN collects
36 a lot of data itself; what does your data collection
37 methods tell you about outcomes? Can outcomes be measured?

38
39 DR DEVENY: I think this is kind of the key kind of take
40 away in relation to outcomes, that you have to collect the
41 data when the services are delivered and then you have to
42 look at it, then you need to share it. Collecting the data
43 on its own is not sufficient, there needs to be a system
44 where that data is used effectively to drive innovation,
45 quality improvement, patient safety, all those really
46 important things.

1 So, in my primary health network, and it's no
2 different to others, all our funds are contracted on the
3 basis of outcome delivery. We don't fund anyone for inputs
4 or widgets, and so, we do collect data on every single
5 service. This is labour-intensive. It's a lot easier to
6 send the money out in a block and every six months ask for
7 a two-page report.

8
9 But if I come back to my first principle, that's not a
10 good spend of tax payer money, that's not a good service
11 necessarily for clients, that's kind of winning it there,
12 you hope it works.

13
14 It's really critical that we collect data and then we
15 share it. We share it with the service providers. So, in
16 our case we provide de-identified benchmarking data so
17 people can see how they're going. We use that data to
18 contract manage, and the two sources primarily are, again,
19 that population health data as well as the data that comes
20 back from the service providers and all the clinicians -
21 the consumers themselves about how things are tracking.

22
23 I think if you've got all that data - in other cases
24 the data is collected but not used. That baffles me. It
25 should be used, it's everyone's data, it should be going
26 back to the clinicians and the services so they can see how
27 they're tracking. Consumers should have a sense of how the
28 system is working; that would instil hope, amongst other
29 things, that this very, you know, big system which is
30 funded quite substantially actually does make a difference
31 and I believe it does, but without the data to demonstrate
32 that it's easy for people to kind of poke holes and poke
33 fun perhaps too.

34
35 MR O'MEARA: Thank you. The question of data, I imagine
36 the answer to the question I'm just about to ask you is
37 shorter than one might think, but the sensitivity with data
38 of course is that, if you require people to give you data,
39 they might be giving you answers that cast them in a bad
40 light. How do you deal with that problem, and I imagine
41 the answer is, they're required to do it in order that they
42 get their funding at all.

43
44 DR DEVENY: So, I actually think that most organisations,
45 the issue is more around data systems and the capacity to
46 collect data rather than an unwillingness. I mentioned
47 earlier that there's a lot of leadership in mental health;

1 I think organisations really believe in what they're doing
2 and they actually want to show it,
3

4 So, our experience is that people will give you their
5 data. If they don't do it initially it's more a capacity
6 issue than an unwillingness to provide it, and then you sit
7 down with the group and talk to them, say three or
8 six months in when you have enough of that information to
9 share it. And the conversation almost always goes the same
10 way: first of all it starts off with this comment, "That's
11 not our data." Because people have never really looked
12 carefully at their own data. They have their own
13 assumptions about their performance, and when you show them
14 what that looks like in a qualitative and quantitative
15 form, it looks unfamiliar, so you often have to show them
16 that it actually is what they've given you because they've
17 never seen it aggregated in the way you show it.
18

19 The next thing that happens is normally an expletive,
20 when people realise that is actually their performance and
21 it's not what they thought it was. They may be doing
22 better in some areas than they thought and, you know, that
23 can be quite joyful, "Wow, look at that" or it may not be.
24

25 Then the third stage is always, and in our area I've
26 never seen it anything other than a strong commitment to
27 improvement. So, once people can see where they are, they
28 all want to improve. It's very rare to find somebody
29 working in health who doesn't want to do a good job.
30 Generally we're not paid well, so we're there for other
31 reasons, we want to make a difference for community, and by
32 giving providers and clinicians back data to show them how
33 they're going you give them the opportunity to improve in a
34 way that is beneficial for them, for the service providers,
35 for the spend and for the community. It's very powerful.
36

37 MR O'MEARA: Thank you. Right, Ms Bartholomeusz, back to
38 you. Consortia, where you're not in charge, have you
39 thought of an example in the experience of your
40 organisation in that setting?
41

42 MS BARTHOLOMEUSZ: I have a couple of examples actually.
43 So, the first would be our prevention and recovery care
44 services, so known as PARCs. So, PARCs are residential
45 services that help people with mental illness who are
46 leaving hospital or would benefit from a 24-hour support
47 service to avoid hospitalisation. Not to be confused with

1 the stepped model of care, but it is described as a
2 step-up/step-down model. And so, in that partnership
3 Melbourne Health is the lead agency.
4

5 We're also involved in the early intervention
6 psychosocial support response program and that's a program
7 for consumers with mental health diagnosis in clinical
8 services, supporting them to engage with the National
9 Disability Insurance Service. We're also a member of that
10 partnership, and again, it's Melbourne Health that is the
11 lead agency.
12

13 MR O'MEARA: What's been your experience of relations
14 between the agencies, bearing in mind the kind of
15 philosophy you referred to earlier where the lead agency's
16 obviously got to be in charge but work co-operatively with
17 the others?
18

19 MS BARTHOLOMEUSZ: That's right, and I think, you know,
20 it's about developing those working relationships, Stephen.
21 It's about respecting individual workers and staff who are
22 employed in these programs or services, respecting that
23 organisations have different skills and expertise, and by
24 bringing a range of skills and expertise to a situation or
25 to a client means that there's a better outcome for the
26 client.
27

28 And so, I think it's that sort of interdisciplinary
29 practice really that produces that outcome, and it's very
30 good working relationships with those other partners; being
31 a trusted partner in the delivery of someone's care.
32

33 MR O'MEARA: Thank you. I can say for the benefit of the
34 Commissioners that we've conducted so far a scenic tour
35 through the foothills of community-based mental health but
36 we're just about to scale a mountain because during the
37 course of the conclave each of our panel members considered
38 what were there described as tweaks in the existing system
39 bearing in mind that we don't have an unlimited chequebook
40 and unlimited funds to just do everything and anything you
41 like.
42

43 But where change might be most beneficial in order to
44 improve the system that we already have and to make it
45 function in a more functional way, and those priorities and
46 tweaks were identified at some length, so I might spend the
47 next 20-odd minutes asking our panel to address some of

1 those.

2

3 The first of them concerned the vision of hope and the
4 need for a vision of hope, and Associate Professor Moylan,
5 that's something that you spoke passionately about and I
6 might ask that you can address that issue first.

7

8 ASSOCIATE PROFESSOR MOYLAN: Sure. I made reference in my
9 statement around the culture - the sort of existing culture
10 of community-based mental healthcare from an area mental
11 health perspective. I think that one of the things that
12 I've observed over time, and obviously I'm relatively, you
13 know, new in the system per se and I defer to people with
14 much more experience than me, but when I observe the models
15 that we run they're very much models that are reflective of
16 the institutional era; in that, it has a very definite
17 model around partnership and reactivity to care, but not
18 one which is necessarily driven around hope and recovery,
19 and our expectation that people should come into our
20 system, receive benefit and then move on with their lives.

21

22 The notion that we serve a really important function
23 in society, in that, a societal principle which is that we
24 provide a platform for people to be able to get people up
25 to a level of functioning and interaction with society such
26 that they can then use their own individual skills, talents
27 and choices to participate in society as a whole.

28

29 So, I think it's a really important component of the -
30 what we need to do to change the system is to communicate a
31 message that, not only is recovery possible, it's expected.
32 And I just have the parallel with cancer care as an example
33 to this. Cancer care operates under the premise that we're
34 going to do everything we can, not only to treat, you know,
35 treat your cancer, we're going to cure you of cancer. And
36 not only that, we're not just going to cure you of cancer,
37 but your experience is going to contribute to the curing of
38 cancer overall. There's an aspiration and a hope within
39 that message of the structure of care that's provided that
40 is all about actually, you know, achieving those outcomes.

41

42 Mental health doesn't have that at the moment in a way
43 that I think is unified across the system, and it doesn't
44 have that in a way that we invest in our research, it
45 doesn't have that in the way that we partner with our
46 services, and it certainly doesn't have that in the way
47 that we measure the outcomes of the care that we provide.

1
2 So I think that's a really core component of the total
3 package of what I would hope out of the Royal Commission is
4 a clear and defined message that actually when people come
5 into the mental health system, they should leave that
6 mental health system, you know, having received top quality
7 care, but we expect them to leave; you know, we don't
8 expect people to stay in a system for ever, you know. And
9 we want people to be able to, you know, actually express
10 and achieve their goals and hopes with the assistance of
11 the system, but hopefully with independence at some point
12 in the system as well.

13
14 MR O'MEARA: Is replacing the existence of present low
15 expectations with high expectations, is a part of that
16 addressing the issues of stigma that you identified at the
17 outset?

18
19 ASSOCIATE PROFESSOR MOYLAN: Ah, I have to think about
20 that question. I mean, I think the broad answer would be,
21 yes, because I just think at the moment, if you observe our
22 system - and Elizabeth picks this up very well - we don't
23 have a series of robust-related outcome measures that are
24 actually about, you know, what we put into our system is
25 going to achieve an outcome, we don't flow that through in
26 any way.

27
28 If we can turn our expectations from being low or
29 absent to being high, then I think we can provide, you
30 know, certainly - then I think the way we structure around
31 that will provide an environment which actually says, yes,
32 we can you do things, and you're welcome and you should be
33 provided care, but for the care providers it also provides,
34 this is a place where you come and make a substantial
35 difference.

36
37 When I speak to my colleagues here, they know that,
38 but the problem is, they've self-selected into this space
39 and we have a significant workforce issue option. For
40 people who don't come into mental health and choose other
41 disciplines, some of the common refrains are, like, it's
42 too hard, people don't get better, like, you know it's not
43 there, it's not aspirational, it's not something I want to
44 dedicate my life to. So, I think if we can set a
45 foundation that has those high expectations I think we can
46 achieve multiple aims.

1 MR O'MEARA: Thank you. Ms Bartholomeusz, going back to
2 you on the topic of workforce, the impact of the NDIS has
3 been observed in some of the witness statements, but one of
4 the points that was made in the conclave was that there's a
5 need to rebuild the workforce, the mental health workforce,
6 and if that's the case how do you do that in order to
7 address these issues of stigma and to infuse hope or, if
8 you like, high expectations? Is that something that needs
9 to be prioritised and, if so, how is it to be done?

10
11 MS BARTHOLOMEUSZ: Thanks, Stephen. It absolutely does
12 need to be a priority. So, in building or tweaking our
13 mental health system in Victoria, and thinking about the
14 community-based mental health services, we absolutely do
15 need to rebuild our workforce.

16
17 So, our experience has been that, with the transition
18 of community health-based funding, community mental
19 health-based funding within community health services being
20 transitioned to the NDIA we've lost a very skilled,
21 experienced and committed workforce in Victoria and any new
22 community mental health service will need to rebuild that
23 workforce.

24
25 The workforce needs to be contemporary, it needs to be
26 able to work in a range of service delivery options. So,
27 with Covid-19 we've seen the move to telephone, telehealth,
28 other modalities, and so a new workforce needs to
29 absolutely be able to work in a range of service provision
30 modes.

31
32 One of the areas that I think is particularly
33 important is ensuring that there's cultural - cultural
34 safety is considered when we're rebuilding that workforce.
35 So, ensuring that we're building a workforce that reflects
36 the communities that we serve. So, in terms of our
37 community mental health workers, ensuring that that safety
38 exists, but also looking to our peer workforce, so people
39 with lived experience who can offer so much to people who
40 are currently experiencing mental illness. So, that peer
41 workforce also needs to be a component of any future
42 workforce and the aspect of cultural safety as well, so our
43 workforce reflecting the cultures of the communities that
44 we serve.

45
46 How do we do that?
47

1 MR O'MEARA: Yes.

2

3 MS BARTHOLOMEUSZ: Million dollar question.

4

5 MR O'MEARA: Usually the starting point is to talk about
6 training and education.

7

8 MS BARTHOLOMEUSZ: That's right.

9

10 MR O'MEARA: And where does that happen and what's the
11 content of it?

12

13 MS BARTHOLOMEUSZ: That's right. It happens, I think, in
14 a range of settings and in a range of places and I think,
15 going back to Steve's comment around the stigma and
16 discrimination that comes with working in - you know, our
17 experience is, you know, committing your life to public
18 health, then committing your life to community health - and
19 working your community health in the west is probably about
20 as low as you can get - but really addressing those issues
21 of stigma, that this work is valuable, it's rewarding, it's
22 critically important, and that has to happen early. It has
23 to happen in our secondary schools, it has to happen in our
24 universities.

25

26 We have to look at different opportunities for being
27 able to train the workforce, particularly if you're
28 thinking about, you know, supporting, developing, growing a
29 peer workforce and the range of - you know, providing
30 suitable training options for that workforce; very, very
31 important, otherwise we're not going to build the workforce
32 that we need for a future mental health system in Victoria.

33

34 MR O'MEARA: Does it follow from what you've just said,
35 that it's beyond just training your existing workforce or
36 even your putative workforce, what you're doing is engaging
37 in health promotion across the community about the
38 importance of what you're seeking to achieve and to have a,
39 as you say, culturally sensitive and properly skilled
40 workforce in a very important area of health?

41

42 MS BARTHOLOMEUSZ: That's right. That's right, and I
43 think that promotion, you know, it has to happen early;
44 that has to be - you know, we have to make it attractive
45 early and talk about the rewards and the recognition that
46 can be achieved.

47

1 But also too it comes to remuneration of this
2 workforce. So, for years we've advocated for this
3 workforce to be remunerated at a much better level than it
4 currently is and I think, you know, until you address those
5 kind of structural issues of remuneration, that will
6 continue to be a challenge; to actually engage enough
7 interest in mental health as a career because that's what -
8 you know, we want people to come into the system, we want
9 them to build their career in mental health, for there to
10 be longevity and, you know, for it to be a rewarding clear,
11 but you need to address remuneration as part of that.

12
13 And that's certainly a challenge for us, you know,
14 competing with the private sector in terms of remuneration,
15 it's constantly a recruitment and retention challenge.

16
17 MR O'MEARA: Thank you. Dr Deveny, how is this workforce
18 priority to be developed from your perspective?

19
20 DR DEVENY: So, I first of all would like to support
21 Nicole's comment about "pay them more". While our only
22 measures really of success, and I think this is critical,
23 are about throughput, then you're looking for a low cost
24 and we see that reflected in the way that we fund services
25 and the expectations we place on them.

26
27 So, if this work is difficult, I can't help but
28 comment that it's often undertaken by women also and poorly
29 paid in many cases, so I think the funding models need to
30 keep that in mind.

31
32 You spoke about credentialing also, Nicole, and I
33 think that's important too. You can justify that people
34 are paid a fair wage when it looks like they have the
35 qualifications to deserve it. So, I think that is really
36 important, and then I come back to the issue about stigma.

37
38 While the notion that you work - and I'm going to
39 speak about drug and alcohol - in the drug and alcohol
40 space, means that you cannot at the family barbecue, not
41 that we're allowed to have those at the moment, indicate
42 that that's where you work without fear of retribution
43 means that, how are you possibly going to get our best and
44 brightest into these areas?

45
46 We as a community, we haven't really had the
47 conversation about drug and alcohol. I'd argue that we've

1 had it a bit about mental health, and perhaps a little
2 about suicide, and not very well about other areas such as
3 alcohol and other drug, trauma, perhaps a little bit about
4 family violence, and certainly nowhere near enough about
5 homelessness.

6
7 Often people with significant mental illness
8 experience stigma for a range of reasons, not only their
9 mental illness. And just as Steve particularly described,
10 the overshadowing of a mental illness meaning that people
11 don't get good physical care, the layers and layers of
12 stigma that someone might experience who either receives a
13 service or is working in that area will significantly
14 determine where they want to work and why.

15
16 We find in general practice that many GPs are quite
17 interested in these areas but the funding is not sufficient
18 for them to make a career out of it. So, they might do an
19 afternoon or a day working in this area and the rest of the
20 time do other work which allows them to pay their mortgage
21 and their bills.

22
23 We shouldn't be having our best and brightest who
24 actually want to work in this area making not unreasonable
25 decisions about their own welfare and their family's
26 wellbeing as a mechanism for deciding where they work. If
27 you work in drug and alcohol you should be paid what you
28 work in - if I use your example, Steve - cancer. Right,
29 the same kind of work should be paid in the same way, and
30 the stigma should also be removed.

31
32 And I actually think that there was stigma about
33 cancer years and years ago when people didn't think that
34 you would survive, and now that cancer's much more
35 treatable, in a sense it's more sexy.

36
37 I believe that our treatments for drug and alcohol and
38 also for mental health do work for most people, and so, you
39 know, I'm hopeful that over time that message gets out
40 clearly, that starts to break down some of that stigma
41 which I think is really impacting in many ways on our
42 workforce.

43
44 MR O'MEARA: It's, with respect, a very interesting
45 point that you've made linking, if you like, the status of
46 the workforce to the outcomes that the workforce can
47 achieve. If you don't know the outcome, then it's easy

1 then to downplay or not understand the importance of the
2 workforce that you're retaining.

3
4 That then leads to another area of tweaking, if you
5 like, which you've already addressed at some length and
6 that's the area of data. Is there anything more to say in
7 connection with the area of data other than to say it's
8 another area of particular priority?

9
10 DR DEVENY: I think it's the comment that, Nicole, you
11 made earlier about data systems and compliance, that's
12 probably worth just reinforcing here and I think that this
13 is a core challenge for us all.

14
15 When we start talking about actually wanting to
16 measure what the public value is being created through the
17 funding of these services, then we need to ask ourselves
18 how? What is the data that we're hoping to collect and how
19 will we use it?

20
21 In Victoria, we're blessed in many ways, but the
22 devolved governance that we have in our health services,
23 and added to that the additional funding coming from other
24 areas, has led to a plethora of IT solutions both within
25 services and across different clinical environments, and
26 this has really limited our ability to understand the
27 patient's whole journey, collect data about their overall
28 outcome.

29
30 So, if someone sees my services, perhaps they also see
31 a community health-based service, even Steve's service: for
32 a start, we don't know because we can't see that, and then
33 we can't really understand what drove their outcome. And
34 I'm fond of saying, maybe they got a puppy, and perhaps
35 that's what improved their mental health more than anything
36 else than any of these services did. To be honest, we
37 don't know.

38
39 And so I think that, while I believe our services do a
40 terrific job, we should know that and we should be out and
41 proud about it and be able to share that, and then of
42 course to challenge notions of stigma and to demand our
43 fair share of funding to deliver what is really very
44 important care for all Victorians.

45
46 MR O'MEARA: You've mentioned sharing; is sharing
47 critical?

1
2 DR DEVENY: Yes, because people don't exist in a bubble of
3 only one service allocation. We've talked about, for
4 example, the physical and the mental health needs and the
5 social needs of somebody. We need to be sharing across
6 those elements as well as then across acuity to really
7 deeply understand overall how people are experiencing care
8 and where we need to improve, and then we can undertake
9 those tweaks, whatever they are, of the component parts to
10 get us to the better.

11
12 MR O'MEARA: Thank you. Ms Bartholomeusz, sharing can
13 happen if your IT systems are linked to one another. Can I
14 ask you to address that particular area of priority.

15
16 MS BARTHOLOMEUSZ: Thanks, Stephen. So, I think I might
17 have discussed this last week about the lack of integration
18 or interoperability between IT systems and it goes again to
19 the issue of reporting and compliance, that when new
20 funding is received from State or Commonwealth, it more
21 than likely comes with its own dedicated reporting
22 information collection system.

23
24 And so, you know, at cohealth we have up to maybe 11
25 different client information collection and reporting
26 systems and none of these systems actually speak to each
27 other, so we have multiple - you know, clients in multiple
28 databases across multiple systems and we need at our end to
29 actually bring all of that information together and report
30 client information.

31
32 So, it's extremely challenging for an organisation to
33 have to manage these systems, but we're thinking about, as
34 Elizabeth was saying, you know, the common client, that
35 these clients are using multiple services within
36 organisations, they're accessing services across many, many
37 different organisations and we only want these clients to
38 be telling their story once, not having to repeat their
39 stories multiple times. Then we absolutely need a level of
40 interoperability to enable that to happen.

41
42 I also have great concern around clinical governance
43 and actually having systems with interoperability which can
44 ensure that our clinical governance is as it should be,
45 that the care that we're delivering to clients is of high
46 quality and is safe. My great concern is that, if these
47 systems don't speak to each other, and if we're collecting

1 a client's information in this part of the organisation
2 about, you know, their general practice visits or their
3 physiotherapy visits which isn't anywhere aligned with
4 their alcohol and drug services or their mental health
5 services, you know, how do we ensure that we have good
6 clinical governance?
7

8 And then if you're talking about a consortium or a
9 partnership, how does that partnership - what is the system
10 that that partnership uses? So, yeah, collection of data,
11 interoperability of IT systems is a real issue and
12 something that must be addressed in the new Victorian
13 mental health system.
14

15 MR O'MEARA: Thank you. A final couple of points before
16 my questions will end and then the Commissioners will get
17 to ask their questions, and I don't want to impinge on
18 their time, but a couple of other areas of priority which
19 are identified during the course of the conclave.
20

21 One concerned the need to address comorbid substance
22 abuse, and Associate Professor Moylan, I can remember you
23 saying something about that; I wonder if you could address
24 that particular area.
25

26 ASSOCIATE PROFESSOR MOYLAN: I will, I just want to say
27 one thing about data and this is just a live example.
28

29 The Commissioners may be aware, Barwon Health was the
30 subject of a significant cyber attack last year which
31 essentially shut down many of our clinical systems. The
32 sad reality is, that didn't really make much of a
33 difference to our mental health service delivery. And when
34 you think about that, what that means actually is that
35 we're not using any of the leveraged opportunities, the
36 information technology that could provide to improve our
37 care, so that's how far back we are and where we're coming
38 from. So, I think that's just a little illustrative point.
39

40 In terms of alcohol and other drugs, I think again
41 this speaks to the way the system has been governed and
42 designed. I just made the point last week, we know as an
43 example there is significant comorbid substance use issues
44 in the consumers that we work with on a daily basis. If I
45 walked down to my inpatient unit now, I would have to
46 estimate that 50-60 per cent of people at least had some
47 comorbid substance issue, whether that be illicit or

1 whether that be licit contribution to their presentation.

2

3 However, it's not like I have a team of people down
4 there who are drug and alcohol specialists providing
5 secondary care and consult and uniformity, which suggests
6 to me that the design of our systems and the carriage
7 that's been brought forward around this has just remained
8 the same. We have not adapted to the greater understanding
9 that we have around consumer needs and inputs, so we're
10 carrying a very similar structure, and I call it reversing
11 or institutional structure of care, all the way through our
12 system at an area mental health service level that's been
13 the same essentially for a long period of time, and the
14 things that have changed is, we've just shortened down how
15 long people stay in the system.

16

17 If we were serious about this and looked at individual
18 consumers' needs we would have robust specialist addiction
19 psychiatry, drug and alcohol specialists working with
20 people in that area because we would see this as a critical
21 opportunity: someone has become so unwell they've ended up
22 in an ICU, in an intensive care unit. We should be doing
23 everything we can around their holistic needs to ensure
24 this never happens again, but we just don't do that at the
25 moment.

26

27 MR O'MEARA: Thank you. Final point, Dr Deveny, concerns
28 families and carers, that's something that you've referred
29 to in your statement, but it was also identified as an area
30 of particular priority and it's got a funding element to it
31 as well, I wonder if you could address that issue.

32

33 DR DEVENY: Yes. So, the core challenge here is, how do
34 we provide services to families and carers when perhaps
35 their family member is not yet engaged in service but the
36 person's behaviours are having a very significant impact on
37 families? How do we manage supporting families when their
38 client, if you like, their loved one, is refusing service
39 given that so many of our service models rely on the client
40 as the key to opening the money box?

41

42 So, if I'm willing to take a service, then that
43 service may - and they don't all - offer family therapy,
44 brokerage funding or some other things to support my
45 family. But while I refuse service, the family's not a
46 client either.

47

1 So, we need to think about how we can provide services
2 both to families where clients are engaged in service and
3 to families where clients are not yet engaged in service
4 but the consequences of their ill-health are being felt
5 quite significantly.

6
7 Families and communities are incredibly resilient;
8 again, they're often very efficient, if you give them a
9 small amount of resource they do amazing things with it.
10 So, how can we really encourage that resilience and that
11 community to support and hold people in times of trouble
12 and stress?

13
14 More broadly, and I spoke earlier about this when I
15 talked about people moving in and out of various service
16 elements, when people are in their family environment
17 sometimes this can be differ for them. How do we provide
18 support, and in some cases education also, for families so
19 they can better support people who are living with them and
20 experiencing mental ill-health or substance use disorders?

21
22 So, these things are all important if we want to
23 ensure that people sleep in the bed they want to sleep in,
24 which is most likely their own in their own home if they're
25 lucky enough to be in a home, and that the people who love
26 them are able to care for them as best they can, so that
27 then we come back to using the money wisely, taking the
28 load off the system, and then being able to re-allocate
29 those funds where people perhaps don't have a home, or
30 there's not the possibility of family support.

31
32 MR O'MEARA: Thank you. Just to be clear about this
33 before I pass to the Chair: between you, you have
34 identified roughly half a dozen areas of particular
35 priority, and if you all say "yes" in unison that would be
36 excellent but you can equally nod, or you can disagree with
37 me if you like.

38
39 But they are: agreeing on a position of hope,
40 addressing stigma, rebuilding the workforce, data and the
41 need for interoperable IT systems; the support to or
42 funding of families and carers, and finally, the need to
43 address the issue of alcohol and drugs. They're the
44 specific areas that you've identified in your consultations
45 between the three of you both in the conclave and today; am
46 I right?

1 DR DEVENY: Yes, that's right.

2
3 MS BARTHOLOMEUSZ: (Nods.)

4
5 MR O'MEARA: Thank you all - sorry?

6
7 ASSOCIATE PROFESSOR MOYLAN: Yes, I would just add one
8 thing which is slightly outside, it relates to workforce,
9 but the importance of supporting the leadership. I think
10 it's a very critical component. There are a lot of leaders
11 across the system as Elizabeth has identified, but I think
12 for the changes to be made in the system we have to support
13 a generation of leadership to come up and actually enact
14 that change, and that's just not simple. There's not
15 people who are - there are people around leading all the
16 time, but we have to find a way to support and bring
17 together that leadership to work together.

18
19 MR O'MEARA: Do you have any views about how that could be
20 facilitated?

21
22 ASSOCIATE PROFESSOR MOYLAN: Ah --

23
24 MR O'MEARA: I suppose the answer to that is, if you knew
25 that, you'd be the Premiership coach in the AFL every year.

26
27 ASSOCIATE PROFESSOR MOYLAN: Well maybe, yes. But I
28 think, you know, part of it is, once again, I think all of
29 the other factors you talked about, particularly stigma and
30 the building of workforce are very important components to
31 actually enabling that leadership, but I think it's very
32 important, yeah.

33
34 MR O'MEARA: Thank you to all of our panel members so far.
35 If I can now just past firstly to the Chair who might be
36 able to commence the Commissioners' questions.

37
38 THE CHAIR: Thank you very much, Mr O'Meara.

39
40 I have three questions, one of them has just been
41 answered in relation to families and their engagement in
42 care and support by Dr Deveny, so two others I've got.

43
44 The first one is, we've talked about, in our future
45 community mental health system the importance of a vision
46 of hope, and I find that very powerful, but also consumers
47 having choice, efforts put into engaging them, and then

1 trusting the services that are being made available to
2 them.

3

4 How do we reconcile that - and I might ask you,
5 Associate Professor Moylan, to address this - with our very
6 high use of compulsory treatment in Victoria and ongoing
7 Community Treatment Orders, some of the duration of which
8 quite surprises me.

9

10 So, when you think about our future community-based
11 mental health service, what place do you think ongoing
12 community treatment, compulsory community treatment has?

13

14 ASSOCIATE PROFESSOR MOYLAN: There's absolutely no doubt
15 that we have high rates of Community Treatment Orders in
16 Victoria, you know, compared nationally, internationally
17 et cetera, and my view is that for the most part, if you
18 read the legislation clearly, it doesn't mean much. So I
19 think actually it speaks to more a culture of how we view
20 care and control than it really does speak to anything
21 else, and I'll give you an example that happened here
22 locally.

23

24 When the 2014 Mental Health Act came in in our area, a
25 particular psychiatrist [REDACTED]
26 [REDACTED] said, I can't actually see now, with
27 the change in the Act, what the role of the Community
28 Treatment Orders are. So, he actually took everyone off
29 them, all the people in his community off them, and we
30 really noticed not a lot of change.

31

32 Because really a Community Treatment Order in the end,
33 you know, is trying to enforce something in a legislative
34 capability that actually is just about engagement with
35 people. If you engage people around their care, for the
36 most part you can do things, and we have other provisions
37 in the Act around assessment orders, et cetera, for acute
38 deterioration that can be utilised if needs be.

39

40 So, I do wonder though about the nefarious influence
41 that capacity of the system has had in the utilisation of
42 Community Treatment Orders going forward and the
43 justification for the continuing to provide care for some
44 consumers because they are under CTO [Community Treatment
45 Order] whereas, if they weren't, would have to be, you
46 know, discharged from the system from a purely capacity
47 capability point of view.

1
2 So, in terms of providing consumers choice, I think
3 that, you know, we are positioned like the rest of the
4 system I think. But, you know, if I ask all of my
5 colleagues across the system, I don't think I'd get a lot
6 of disagreement actually that we want consumers to be
7 provided choice. People are having choices all the time
8 about their own choices in their lifestyles, and behaviours
9 et cetera, and our role is to partner with people to
10 provide specialist advice and support and care where
11 required.

12
13 But we also have this little, little obligation to
14 provide a safe net for certain people at certain times, but
15 we've extended that out in a control mechanism - part of
16 it's carryover from the 1986 Act, but part of it I think is
17 just carryover from an institutional era where we kind of
18 think, well, this person is X, they're going to need this
19 treatment for life, they'll need this depot medication
20 forever and they can stay under a CTO, which in actual fact
21 isn't true. And I do think, adding to that, there is a
22 contribution of resource allocation and justification for
23 that.

24
25 THE CHAIR: Thank you very much. Another issue I just
26 wanted to take up is the fact that you've all talked about
27 the need for greater coordination.

28
29 And, Dr Deveny, you talked about wasted
30 effort/duplication that can happen if there's not good
31 coordination, and I think Associate Professor Moylan gave a
32 good example in his witness statement about a local PHN and
33 the Area Mental Health Service both commissioning services
34 simultaneously without knowing about that. And we've heard
35 I think from you too, Ms Bartholomeusz, about the impact of
36 having these multiple forms of funding coming into an area.

37
38 I read with interest those comments in your
39 statements, but I'm trying to think about how do we do it?
40 So, Dr Deveny, what do you think we could do to actually
41 give effect to this desire to have better coordination and
42 reduced duplication? Because right now we have both the
43 Commonwealth and the states through the PHN and the Area
44 Mental Health Services commissioning a lot of work that is
45 very similar in nature.

46
47 DR DEVENY: Yep, thank you, Chair. That does speak to the

1 issue that I raised at the beginning, my first comment,
2 which is "use the money better".
3

4 So we do have, as you pointed out, various funding
5 streams, but what we don't have is an agreement about what
6 we're trying to achieve for the community and whose job it
7 is to do what.
8

9 In drug and alcohol the Commonwealth has recently
10 developed in consultation a drug treatment framework which
11 looks at all the component parts of the system, and then
12 the next question is, who's responsible for funding which
13 part, and what outcome are we expecting from each one of
14 those pieces? So, I think it's really critical for us,
15 when we think about using the money better, to really
16 understand that outcome piece.
17

18 So, it seems simple; you know, the State Government
19 funds kind of hospital-based services and the Federal
20 Government funds primary care services, but actually it's
21 much blurrier than that in reality, so there needs to be a
22 conversation. And, I love the idea of Victoria working
23 with the Commonwealth and agreeing to be the showcase for
24 how you can do this bilaterally well, where we agree what
25 are the outcomes we want to achieve from our system, who is
26 responsible for providing what measure of funding into
27 that, and then having a regional coordinator of those
28 efforts to ensure that we are accountable to those outcomes
29 through that leadership and the mechanism of data, kind of,
30 collection and sharing.
31

32 THE CHAIR: Thank you. Certainly we know this is an issue
33 we're going to have to address at some point - well (a), in
34 terms of our future development particularly of the
35 community-based system.
36

37 So, Professor McSherry, can I hand to you now first
38 for your question.
39

40 COMMISSIONER McSHERRY: Thank you. Just one question for
41 Ms Bartholomeusz. You mentioned in your statement and just
42 before about the importance of the peer workforce, and
43 certainly we've heard a lot of information about how this
44 can work in a system, but at the same time there's a fear
45 that it could just be tokenistic because this is just a
46 health service, or a mental health service, you don't have
47 peer workforces in cancer services as such, even though I

1 think that's changing.

2

3 So, I'd be interested in your views as to how best to
4 navigate those challenges to ensure that the voices of
5 consumers and carers in peer workforces are embedded in
6 community mental health.

7

8 MS BARTHOLOMEUSZ: Thanks, Commissioner. So, community
9 health is really committed to ensuring that there is
10 consumer voice in the design and delivery of
11 community-based mental health services, and our experience
12 of employing a peer workforce demonstrates that it is a
13 very useful way of actually connecting and building trusted
14 relationships with people who experience mental illness.

15

16 So, we've embarked to make peer workers a part of our
17 healthcare team, but also to looking at how we can support
18 those peer workers in the workforce, so in terms of
19 training, development and career, so that it's not
20 tokenistic, that it is meaningful.

21

22 We know from our experience that people experiencing
23 mental illness - and I don't think that it's, you know,
24 just isolated to mental illness, I think it goes across
25 broader sort of health issues - is that, listening to a
26 person or being able to speak to a person who has had a
27 very similar experience to the experience that you're
28 currently having actually drives better outcomes and
29 promotes behaviours of improvement.

30

31 And so, having that peer workforce is critical in our
32 organisation: we have peer workers in our homeless team, we
33 have peer workers in our drug and alcohol team, we have
34 peer workers in our refugee health and in our Aboriginal
35 and Torres Strait Islander teams, so making those
36 connections, building those relationships with people so
37 that they can engage in our services has been absolutely
38 critical.

39

40 But I think your point about, how do you make sure
41 that that's not - that workforce isn't tokenistic, and that
42 is by ensuring that you invest. As an organisation, we
43 invest in their training, development, they have regular
44 supervision; we have appropriate systems and policies and
45 procedures in place to guide their work, but we're actually
46 investing in them so that they do have a career, a career
47 path they can follow if they choose to.

1
2 COMMISSIONER McSHERRY: Thank you very much.

3
4 THE CHAIR: Dr Cockram.

5
6 COMMISSIONER COCKRAM: And, thank you to all the panel for
7 a great discussion today and for all your witness
8 statements.

9
10 I wanted to ask my question to Ms Bartholomeusz,
11 somewhat related to your witness statement but also to the
12 discussion today.

13
14 It is often confusing in this discussion about what is
15 community mental health and what is the specialist
16 community mental health response that Associate Professor
17 Moylan has been talking about.

18
19 In your statement you talk a bit about the Trieste
20 model and about other models that promote a community
21 mental health that is very grounded in community and
22 grounded in a primary care integrated setting.

23
24 In that model, what do you think the role of the
25 specialist area mental health system would be, and is there
26 a need for that model in that kind of idea?

27
28 MS BARTHOLOMEUSZ: Thanks, Commissioner. That's a big
29 question. I absolutely do believe that there is a role for
30 a specialist mental health service provider.

31
32 So, as Steve talked about earlier, people move up and
33 down in terms of their level of wellness when they have a
34 mental illness, and I think across the continuum we need to
35 be able to provide the right response at the right time at
36 the right place, and at times that will require an acute
37 specialist mental health service response, so that part of
38 the service system is absolutely a critical part and needs
39 to continue.

40
41 The work that we seek to do in community-based mental
42 health is really to support people to be able to
43 self-manage and to remain in community for as long and as
44 much as possible to avoid hospitalisation, avoid needing to
45 go or seek an acute mental health response. And so it's
46 about, I suppose in a way, keeping people out and thinking
47 about how we keep people out, so how do we keep people well

1 in the community, and that is by working in a
2 recovery-based approach, supporting people to understand
3 their condition, to be able to self-manage their mental
4 illness, but also to think about the social environment in
5 which they live and in which they work, and putting in
6 supportive or putting in protective factors really that
7 will help them to be able to stay in community and not need
8 that acute mental health response.

9
10 I'm not sure if I've answered your question but.

11
12 COMMISSIONER COCKRAM: Yeah, I guess the question is
13 speaking to, in the community setting is there a need for a
14 specialised service, not the more acute crisis, bed-based
15 system which we understand; but in a community setting, as
16 a community provider, is it useful to have specialised
17 teams around you, as you described in the homeless outreach
18 program?

19
20 MS BARTHOLOMEUSZ: Yeah, no, I do; I do believe that. And
21 so, if you look at the Trieste model, if you look at the
22 PARC model, there are models which provide that
23 step-up/step-down approach level of care, and I do think
24 that that is required in the community, because again,
25 people's needs will change over time.

26
27 I do strongly advocate though for investment in the
28 sort of early intervention, or prevention early
29 intervention part of our service system. And so, yes, I
30 think they're needed, but I think we can do a lot more in
31 the community in terms of that community-based support,
32 recovery, working in that recovery approach, providing that
33 psychosocial rehabilitation, but yes, I do think there is
34 also a need for something like the PARC model or a Trieste
35 model on a greater scale.

36
37 COMMISSIONER COCKRAM: Thank you.

38
39 THE CHAIR: Professor Fels.

40
41 COMMISSIONER FELS: (Inaudible).

42
43 THE CHAIR: Alan, you're on mute. Alan, start again,
44 please.

45
46 COMMISSIONER FELS: I'd like to thank all the witnesses
47 for their excellent contributions. One matter I wanted to

1 ask about was outcome measurement and the nature of it once
2 you've got past the obstacles to it. We've heard a lot
3 about the obstacles to collecting it.
4

5 But I just wanted to say that there's been a lot of
6 calls for good outcome measurements, it's been going on
7 for years; in fact, it goes on right across the whole
8 public sector, not just in mental health. And yet - and
9 also, there's really been a big push from the National
10 Mental Health Commission, COAG, it's almost a mantra, and
11 yet somehow, unless I'm mistaken, it doesn't happen that
12 much or even that usefully.
13

14 So, could you - are there any sort of limitations or
15 problems in the nature of the outcomes we want to measure,
16 or why is it that there's been such a shortfall in outcome
17 measure despite all the urging of it? Maybe Doctor,
18 several - all witnesses mention it, maybe Dr Moylan.
19

20 ASSOCIATE PROFESSOR MOYLAN: I can certainly try. I think
21 there's a variety of reasons for that within the mental
22 health space. I think it goes, firstly, to the notion that
23 we haven't been aligned up to actually use these things, so
24 therefore we don't measure, so we haven't learnt and it
25 hasn't become ingrained as part of our culture of actually
26 tying it from measuring an outcome, to a service delivery
27 improvement, to a change, to an outcome, et cetera.
28

29 We haven't established a model of live learning,
30 because that's the point I think in outcome measurement
31 really; it should be, we don't measure outcomes just for
32 the sake or to say we've met a target, but actually it
33 should be we've measured outcomes to know what we're doing
34 but also how we should improve it iteratively, because
35 health services should be iteratively improved all the
36 time, otherwise I think we're doing something wrong.
37

38 I think we haven't come down on - there's no one
39 agreed set of measures, no one measure that's going to
40 capture this, et cetera. And I think probably where we've
41 fallen down in the past is, kind of, an adherence to a
42 couple of measures which are really about a clinician-based
43 subjectivity.
44

45 And, for mine, one of the goals that we have created
46 internally as a health service, we've set ourselves our own
47 internal goals, for the Commissioner's edification, and the

1 key goal for that is that the consumers feel better.

2

3 We don't exactly know yet actually how to measure that
4 in any particular way; that's going to be a combination of,
5 you know, patient or consumer-reported outcomes measures to
6 be able to do that.

7

8 So, whilst I think that PROMS have sort of taken on -
9 you know, they've been around for a while and they're sort
10 of taking steam in other places - I haven't really yet seen
11 them being used sophisticatedly and at a large enough scale
12 to know how it actually influences care, so maybe that's
13 part of the reason.

14

15 But I agree with you, in a sense we often always talk
16 about, "Oh, we need to measure the outcomes", et cetera,
17 but the question is, what outcomes? And I don't think we
18 have an agreed approach on that, and I would only advocate
19 that someone has to decide at some point what the outcomes
20 are.

21

22 Secondly, part of the outcome pressures need to be
23 consumer experience of care, because I think that is such a
24 fundamental part of the benefit that someone will derive
25 from care relates to their experience and not just a
26 subjective measurement of external factors.

27

28 COMMISSIONER FELS: Thank you.

29

30 THE CHAIR: Since we have time can I just ask one more
31 question, because we all talked about the need to develop
32 the capability of the workforce.

33

34 Associate Professor Moylan, I'm interested, in your
35 witness statement, you gave a good example where you said
36 you thought the way we have underplayed the importance of
37 the diversity, the role that allied health and other
38 professionals as well as the peer workforce can play.

39

40 And you made reference to the fact that you thought
41 that even the way the Department was structured around
42 having a chief nurse and a chief psychiatrist function
43 exacerbated or perpetuated that.

44

45 Can you give me a sense of what you think we can do
46 differently to re-envisage that approach to a more
47 diversified workforce in community-based mental health

1 particularly into the future?

2

3 ASSOCIATE PROFESSOR MOYLAN: I just - I noted that before
4 because I think it speaks to, harks back to an
5 institutional understanding of how care is provided. You
6 know, there's nurses and doctors and that's who provides
7 care, and what we know now actually is there is a diversity
8 of skillsets and inputs and functions that a person can
9 benefit from at particular stages of their care, and
10 Nicole's representation of cohealth would be a classic
11 example of this.

12

13 The lived experience input into care is relatively new
14 and I think we are learning the benefits of that
15 progressively going forward.

16

17 So, I think that what I would probably just put on the
18 table is to say that, an individual consumer's needs are
19 individual, and what a service system should be looking for
20 is, who has the expertise to provide that consumer with the
21 function that's required to help them, partner with them to
22 take the next step. Now, that is likely to be a
23 combination of things.

24

25 I wouldn't be so - you know, so presumptuous to say,
26 that has to be a combination of particular disciplines. In
27 some way that might be how we train our future workforce to
28 have the functional capacity to do these additional things.

29

30 And if we're talking about, one of the benefits of
31 having a lived experience workforce is engagement with
32 people because of that lived experience, then I would
33 suggest that an imperative of our training of our workforce
34 is to improve engagement. If we've identified that as
35 being an issue, then doctors, nurses, OT, social workers,
36 et cetera, should have a fundamental focus on how we
37 provide better engagement.

38

39 So, that's what I would propose. I just find it - I
40 just probably made that as a little interesting comment,
41 and I wouldn't propose that you have a chief social worker
42 for mental health or a chief, you know, OT or something
43 like that, because I actually think it kind of devalues the
44 whole process.

45

46 The reason the Chief Psychiatrist exists in my eyes is
47 that it serves as a very clear function around the Mental

1 Health Act and the governance thereof, and I think that is
2 a really important marker.

3
4 And I think the rest of the situation with the Chief
5 Psychiatrist, Chief Mental Health Nurse and other things
6 has, in my view, got tied up with that blurring as I said
7 before: what is the role of a Department funder? Is it a
8 policy provider and a funder, or is it a service provider?
9 And I think some of those extra elements that have been
10 added on over time represent a blurring of those roles
11 rather than a particular need to have those functions in
12 the system.

13
14 I don't think there's a chief intensive care nurse in
15 the Department, and I think we can ask ourselves why,
16 because we don't think of the care like that.

17
18 THE CHAIR: Fantastic, thank you very much, and thank you
19 all panellists for making the time with us and for Counsel
20 Assisting to so carefully lead us through the material
21 before us.

22
23 I think in our interim report we made it clear that we
24 see that, in a reformed mental health system, our
25 community-based mental health system will be at the heart
26 of that, and so, we're really grappling with that at this
27 critical stage in our Royal Commission, how we give effect
28 to that commitment, and today's discussion has been
29 incredibly helpful in focusing on the opportunities that
30 there are to look at where the strengths exist in the
31 current arrangements but where the opportunities for
32 innovation and change might also exist.

33
34 So, thank you all very much for the effort again with
35 your witness statements, giving us the time in the panel
36 discussions today, and Counsel Assisting, thank you very
37 much for leading us through the material.

38
39 So, thank you all, we'll look forward to reflecting on
40 the material you've given us today.

41
42 MR O'MEARA: Thank you. May I also thank all of our panel
43 witnesses. Today it's been an absolute professional
44 pleasure to deal with the three of you through the conclave
45 and today, and thank you very much for your evidence today,
46 it's been of enormous help to the Commissioners as you've
47 heard. So, on behalf of the counsel team, again, thank you

1 very much.

2

3 ASSOCIATE PROFESSOR MOYLAN: Thank you for the
4 opportunity, we really appreciate it.

5

6 DR DEVENY: Thank you for the opportunity. Good luck.

7

8 MS BARTHOLOMEUSZ: Thank you.

9

10 THE CHAIR: Bye.

11

12 **AT 11.55AM THE COMMISSION ADJOURNED**

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