Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF PROFESSOR ALAN ROSEN

I, Professor Alan Rosen, AO, Senior Consultant Psychiatrist and Academic, of 132/85 Reynolds Street, Balmain in the state of New South Wales, say as follows:

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

Background

2 I am a Professorial Fellow at the Illawarra Institute for Mental Health, University of Wollongong. I am also Clinical Associate Professor at the Brain and Mind Centre, Sydney Medical School, University of Sydney.

3 I was born in Perth, Western Australia. I completed my degree in Medicine at the University of Western Australia and subsequently completed my specialty qualifications in psychiatry, sequentially in both the United Kingdom and Australia.

4 Among other appointments, I was previously:

(a) a member of the Project Management and Steering Groups for the Development and Review of the Australian National Mental Health Standards (1993–2009);

(b) a member of the Ministerial Taskforce to form a Mental Health Commission in NSW in 2011; and

(c) inaugural Deputy Commissioner of the NSW Mental Health Commission (2013-2015).

5 During the over 40 years that I have worked as a consultant psychiatrist in Australia, I have advised federal, state and international governments. I have also worked as a consultant psychiatrist, director and clinical director at the Royal North Shore Hospital and Community Mental Health Services (RNSHCMHS) from 1979 to 2009. My work has primarily focused on the integration of hospital and community mental health services, and development and research of community-based alternatives to hospital based services. I have also been working regularly in rural, remote and Indigenous mental health for the former Greater West Area Health Services which devolved into Far West Local Health District (**LHD**) Mental Health Services, for over 35 years.

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

6 My research has been, and continues to be, on innovative evidence- and team- based alternatives to psychiatric inpatient care; recovery and rehabilitation; early intervention in psychiatry; stigma and discrimination; human rights facilitation in mental health care; indigenous and remote mental health; functional outcome measures; better services for impaired practitioners and their families; and dimensions of mental health service system reform. I have had visiting academic and/or advisory appointments at Harvard University, University of Wisconsin-Madison, and University of California in Berkeley. I have recently been a presidential invited speaker for both the American Psychiatric Association (San Francisco, 2019) and the World Psychiatric Association (Berlin 2017, Lisbon 2019).

7 Attached to this statement and marked "AR-1" is a copy of my curriculum vitae.

Interim Report recommendations

8 At the outset, I wish to comment on some of the recommendations in the Royal Commission's Interim Report (**Interim Report**). I see many positives in these recommendations, but in my view there is some fine-tuning that is required.

Recommendation 1: Victorian Collaborative Centre for Mental Health and Wellbeing

9 One of the recommendations in the Interim Report was that the Victorian Government should establish a new entity: the Victorian Collaborative Centre for Mental Health and Wellbeing (**Victorian Collaborative Centre**). The Interim Report notes that the Victorian Collaborative Centre will have research capability and provide translational research for the public and for certain sites (among other things).

10 In short, I think this recommendation is brilliant, as I think workforce is the key to our mental health system. However, in my view the recommendation does not go far enough. We need a national mental health industry-wide workforce institute which encompasses all professionals and support workers, service-user and family peer workers.

11 If the Royal Commission recommends something like an "Australian National Institute of Mental Health" (**National Institute**), then the Victorian Collaborative Centre would be very compatible as a key part of that national institute, or the beginning of it: possibly the inaugural or founding component of such an institute.

12 We need a national mental health industry-wide workforce institute that encompasses all professionals and support workers, including service-user peer workers and family peer workers. My colleague Professor Marree Teesson AC and I, with our expert

interdisciplinary colleagues, have co-designed a proposal for such a national institute.[1] Attached to this statement and marked "AR-2" is a copy of this proposal. We envision that a national institute would have a base in each state jurisdiction. The National Institute would have similar components that the Victorian Collaborative Centre would have, but it would have a wider purpose and scope than the state and territory basis, in that it would provide a national curriculum for each profession, and for consumer peer workers and family peer workers. The National Institute would also provide nationally consistent modular training for upskilling of staff; supervision and mentoring systems; consistent operational guidelines and procedures for standardised evidence-based interventions and service delivery systems; research and translation of research; nationally consistent qualifications; and the engagement service users, families, providers, managers and the public.

13 As to a curriculum, we envision that the National Institute would have standardised curricula, courses and qualifications, and it would provide planning, development and practical implementation materials to all the states and territories. In our view, there should be nationally consistent practice qualifications for each discipline and nationally consistent research programs (in other words, there should be partnership programs between the states and the Commonwealth). There should also be scientific translation for the public, mental health workers and support workers. Moreover, we should have this not only for clinicians, but also for peer support workers.

14 I note that there is no consistent supervision of mental health workers, and there is not the mentorship that is needed. The mentorship should be pastoral, because of the vulnerability to vicarious trauma for mental health workers. Pastoral support for mental health workers should therefore be provided through a standardised and nationally consistent mentorship program.

15 The Victorian Collaborative Centre could be the base for the National Institute. It could be *the* Victorian agency or centre representing the National Institute. All the state centres that provide curricula and content could collaborate with each other.

Recommendation 2: Targeted acute mental health service expansion

16 The second recommendation was that the Victorian Government should provide funding for 170 additional youth and adult acute mental health beds, comprising 135 additional public beds, and 35 additional beds procured from a private provider.

[1] See Maree Teesson and Alan Rosen, "Australian National Institute of Mental Health: A Nationally Consistent Evidence-Based Workforce Capacity-Building Strategy for All Mental Health Service Providers" in Submission No 226 to the Commonwealth Productivity Commission, Mental Health, 5 April 2019, updated 1 July 2020.

17 I can theoretically understand why Victoria should add 135 additional public beds, but I do not understand the addition of private beds, nor the number of private beds recommended. Perhaps the Commissioners are considering a particular part of a catchment that does not have any inpatient beds, and are attaching them to a private institution.

18 Whilst I am not against being flexible in provision of beds, we know from the UK experience that contracting private beds is very expensive and can lead to long-term custodial care a long distance from familiar habitat and family, rather than the best clinical care or local community-based rehabilitation (Professor Helen Killaspy, University College London, Keynote lectures, Sydney Melbourne & Canberra, Feb-Mar, 2020).

19 In terms of the 170 additional acute beds, I understand that the CEOs and some of the senior managers of health services would like these resources, perhaps for diverse health and mental health service purposes, and yet I think the mental health system needs all those resources.

20 However, I do not think they should only be inpatient beds. In particular, we should not have the additional beds as inpatient beds unless we allow for the potential for bed substitution (for example, diversion, if safe, to intensive Hospital in the Home (**HITH**) arrangements). The Royal Commission should recommend, and the Victorian Government should allow for bed substitution, in terms of having beds in other community settings or having HITH mental health teams as substitute for hospital beds. 24-hour intensive community-based mental health team management at home, wherever possible, is certainly not a cheap option, but it is less expensive than hospital based care, and it produces far superior outcomes, on the basis of many randomized control trial studies (for example, Hoult et al 1984, Cochrane Collaboration Reports on Crisis & Assertive Community Treatment teams).

21 In the context of COVID-19, the states and territories may reach a stage where existing beds are under-staffed. For example, if one person becomes infected, that person is likely to spread the infection to several more, and contacts also may need to go into self-isolation. We have already had examples of up to 40 staff at a time in quarantine. When that happens, hospitals have to find substitute staff from somewhere else. But if everyone is running short, they are not going to receive those substitute staff. This could occur during an initial or recurrent spike of COVID-19 infections. To take the pressure off the lack of spatial separation or staffing of psychiatric inpatient units, HITH inpatient diversion programs should be considered.

22 I am aware that there has recently been an announcement regarding the provision of 170 beds, and that there is funding assured for those beds. Some of the 170 beds are for young people, and my understanding is that those beds are being developed in a way

that they can also be used as HITH beds (for more on HITH schemes and bed substitution, see below at paragraphs 23 to 31). This would seem to indicate that the Victorian Government is envisaging some alternatives for the use of those beds.

Hospital in the Home (**HITH**)

23 In NSW (Hoult J, Reynolds I & Rosen A, 1984, Teesson M, Hambridge J, Issakidis C, and others internationally, beginning with Stein L & Test M,1968), there has been extensive research on mental health service HITH schemes. HITH schemes started in the mental health system, and from there, were used in a number of other clinical disciplines, such as cardiac rehabilitation, oncology care and sometimes post-surgical care. Most large general hospitals have an HITH scheme with various components to it. What is often unrecognised is that the evidence base of HITH schemes in general hospitals and health services had been gathered more intensively and over a much longer timespan in mental health, and there have been very encouraging results of using HITH care as bed substitutes in many disciplines.

24 Some general hospital clinicians and managers may say, "*We know it will work for cardiology, and it will work for oncology, but it won't work in mental health - these patients won't co-operate*." But as stated above, the evidence base for their use is strongest and longest in mental health. It *does* work when you engage people properly, and it does not usually depend on coercion. Sometimes people might need to be on a Community Treatment Order (**CTO**) initially but often this can be removed once a sound engagement is assured, as most mental health HITH schemes rely on voluntary engagement.

25 The provision of HITH care is also a potential solution for the bridging of any current spike period of COVID-19 or in a later recurrence, because:

(a) people have more freedom;

(b) people have a better hold on their own selves and identities, because they are in their own homes;

(c) staff can call in as often as the person needs (eg three times a day or more to make sure the person takes their medication and are attending to their self-care etc); and

(d) it can be done safely with appropriate spacing and PPE (personal protective equipment). Moreover, staff are not located in hospitals, where they are more likely to be infected.

26 On the last point, I note that when staff provide HITH care, they do not have to go into the person's home. They can come to the front door and talk to the person. They can make sure the person is taking their medication, but also that they are okay; for example, that

they are getting enough to eat and that they have stable accommodation. It is not just a matter of clinical *health*care - it is also about their *functional* care.

The three levels within mental health HITH schemes

27 In my view, we need to keep workers in mental health services active, keep them outdoors and make sure that they are in the community. In light of this, I see HITH schemes as having three levels or components:

(1) acute bed substitution;

(2) assisting the "missing middle"; and

(3) the full Assertive Community Treatment (**ACT**) model.

28 The first level is acute bed substitution, which I discuss above at paragraph 20. HITH care might be an effective substitute for beds. In my view, some community mental health teams have become quite sedentary, sometimes because their leaders feel more secure in hospitals or clinics and role-model sedentary ways of working. Sometimes the doctors and others who lead those teams do not want to go out of the clinic - they want to run their teams like traditional outpatient programs.

29 The second level is for the "missing middle". The missing middle refers to the gap in treatment for people with moderate mental illnesses. These people seem to miss out on services generally, either because their illnesses are too severe and complex to be treated in primary care, or because their illnesses are too mild to meet the threshold for accessing limited public mental health services.

30 The newly announced Adult Mental Health Centre program is welcomed. A copy of the Australian Government's Consultation Paper is attached at AR-3. However, it is a much less clinically rigorous and less faithful version of the hub scheme than the one that Professor Patrick McGorry had proposed and outlined previously for the Commonwealth Government and the Royal Commission for the "missing middle". Each of the components of that hub should draw on evidence-based, fidelity criteria (standardised operational requirements and guidelines based on evidence for that intervention). Each component needs to be demonstrably cost-effective, and to produce good outcomes. For more on the strengths and limitations of the service hub model, see paragraphs 166 to 167.

31 The third level would be adopting ACT & support teams. The ACT model has 50 years of evidence behind it, and is still evolving. All the community models relate in some way to the ACT model. I note that the most severely and enduringly mentally ill people are the most vulnerable (and they are particularly vulnerable as a result of COVID-19). Among

the most vulnerable people are those who are homeless or near homeless, or who are isolated. These people need to gather together with other people who are going through the same form of clinical impairment. They also need an intensive mobile system for ACT teams. The intensive mobile system would stabilise and improve the lives of individuals with persistent or recurrent psychiatric disorders who would otherwise have their lives in the community disrupted by many revolving door admissions.

Dismantling specialised teams

32 Over recent years, many of the specialist community treatment teams have been dismantled in Victoria and have been replaced by generic (ie not specialist) teams. The evidence-based specialist teams lost in Victoria include mobile home visiting CATT (Crisis Assessment & Treatment Teams) to deal with psychiatric crises in the community, and many local hospital networks (**LHNs**) in Victoria have also dismantled their intensive ACT mobile rehabilitation teams. These teams were for individuals who are the revolving door people in the system - they keep coming back to the hospitals. Because these people have long-term and persistent chronic disabilities, they take up acute beds when they come into hospital. The evidence shows that if you have low caseloads and you work with them at their homes and in local facilities, then you can provide them with both clinical and functional care (Rosen A, Killaspy H, Harvey C, 2013). You can help them with going to doctors' appointments - not just psychiatrist appointments, but physical health appointments too (because many mentally ill people have physical health problems). You can also look after their functional care, making sure that they have their shopping, that they can pay for their rent, and that they do not gamble their money away. You can look after co-occurring drug and alcohol problems, and provide all those supports on a mobile, largely voluntary and cooperative home-delivery basis.

33 Providing this level of care requires cooperation between the state and the Commonwealth governments. Victoria has lost many of its rehabilitation resources, because the rehabilitation teams no longer exist (for example, in Victoria there existed the Psychiatric Disability Rehabilitation and Support Service (**PDRSS**)). A lot of the rehabilitation resources were given up to the National Disability Insurance Scheme (**NDIS**) to provide support work, and that means the state services lost their rehabilitation clinical component (for example, day centres to complement ACT teams). In my view, and that of my co-authors (see below), the NDIS should provide the support component for ACT teams (because they are only mandated to provide support), while the states should provide the clinical components, of combined and co-located ACT and support teams for the most long-term, recurrent or persistent and enduring mentally illnesses.

34 For more detail on my proposal for combining ACT teams and NDIS teams, see Memorandum from Alan Rosen et al to Greg Hunt and Michael Gardner, "Re: Rationale

for and Approximate Costing for Assertive Community Treatment and Support (ACTS) Teams Nationwide, to Operate in Connection with the NDIS with Approximate Costings", *Transforming Australia's Mental Health Service Systems* (20 March 2020).

35 This document has been updated with current costings, up to 2018. One can work out how much it would cost per team, but it would be complementary to the Royal Commission's recommendation of adding 170 beds (see above at paragraphs 19 and 20) if the Royal Commission decides that the alternative to having those 170 beds is to have them as bed substitutes. If you can run this as a bed substitution scheme (and particularly because these people would otherwise be in hospital), and you run it on a 24-hour, 7-day-a-week basis, then the evidence shows that you will both improve quality of life outcomes, and save money on hospital admissions.

COVID-19 response

36 In the meantime, to bridge the COVID-19 crisis, it would be good for the Royal Commission to consider making another interim recommendation: that the State and Commonwealth pool resources to pilot alternatives to hospital beds. This is for three reasons: first, it is safer for most clientele and staff; second, it will reduce the likelihood of staff shortages; and third, it will help address bed shortages.

37 The more you concentrate staff where you have a heavy concentration of SARS-CoV-2 (the virus that causes COVID-19), the more likely it is that the staff will be infected. It is not clear whether it also means that you are more likely to have a more severe infection.

38 It is also possible that we will run short of staff. Absenteeism may come on the tail of that, because people will have reasonable fear: for themselves and their families.

39 The alternative to having staff highly concentrated in hospitals is to have an intensive mobile team that supports people in their homes (people with their families or sometimes people living alone), if safe to do so, whereas those people would otherwise have been hospitalised. The mobile team would have the ability to call in, up to several times a day if need be, while the person is in a sub-acute state. Ordinarily, these people might have come into a respite centre, like a Prevention and Recovery Centre (**PARC**), or they might have come into an inpatient unit.

40 I make further comments on the impact of COVID-19 below at paragraphs 280 to 288.

Recommendation 3: Suicide prevention

41 Recommendation 3 was that the Victorian Government should expand follow-up care and support for people after a suicide attempt. It talks about assertive outreach for engagement of people with self-harm and suicidality (see in particular Chapter 15 of the

Interim Report). In my view, expanded follow-up care could also be integrated with at least two of the three levels described above at paragraphs 27 to 31. In other words, it would be less stigmatising and much more efficient to integrate it with the three-level model, rather than having a separate suicide service.

42 The mobility and flexibility of these home-delivery models may first assist us to get through the COVID-19 era with much less avoidable morbidity and mortality, but it could also be ideal for engagement with people struggling with suicidality in the long run. That is because engagement does not only just happen in the first part of the therapeutic encounter. The assertive outreach could help to create a therapeutic alliance. You have to put work into it for the whole therapeutic encounter, even if that encounter takes some years before the person becomes non-suicidal. The person will eventually value that they are receiving continual support from somebody who cares about and believes in them. That engagement is key to the three levels I have described above.

Recommendation 5: A service designed and delivered by people with lived experience

43 Recommendation 5 is that the Victorian Government should establish Victoria's first residential mental health service designed and delivered by people with lived experience. Although people with lived experience may be prominent in this process, these places should be co-designed with other stakeholders including experienced clinical and residential support workers and committed architects of welcoming and cosy homes and community-based mental health facilities, and not just of institutions.

Recommendation 7: Workforce readiness

44 In my view, Recommendation 7 relates to Recommendation 1, because it also incorporates leadership networks and the need to fund more professionals in particular professions. These things fit together into an overall workforce strategy and an overall workforce initiative. Recommendation 5 also fits within a proposal for a National Institute.

45 As discussed at paragraph 12 above, Professor Maree Teesson AC and I drew up a proposal for a National Institute. My background is in community psychiatry. Professor Teesson is the National Mental Health Commissioner, Professor and Director of the Matilda Centre (a co-occurring disorder institute at the University of Sydney), and Director of the National Health and Medical Research Council (**NHMRC**) Centre of Research Excellence in Prevention and Early Intervention in Mental Illness and Substance Use (which looks at co-occurring disorders between mental health and drug and alcohol). Our idea is to combine the expertise in the workforce for both mental health and drug and alcohol and other co-occurring disorders.

Inclusion of peer workforce in interdisciplinary teams

46 We have recently seen an increasing trend towards including members of the peer workforce in interdisciplinary teams. I welcome the inclusion of the peer workforce, of both service-users and families. However, it is important to be aware that some of the research findings around the peer workforce are ambiguous. Some research looks at whether a peer worker can work as effectively as a case manager, but the findings of such research can be misleading.

47 In the US, where many of the earlier relevant studies have been done (for example the works of Larry Davidson, Yale University, and Gene Johnston et al, Recovery Innovations, Phoenix), the case managers working in mental health services are often not *professional* case managers. They might have a two- or three-year non-specific college degree, and that enables them to get employed as case managers. In the US, however, it is at the masters level that a person is qualified to become a mental health professional like a psychiatric nurse, social worker or occupational therapist. The research has been comparing peer workers with unqualified, not fully professional case managers. The research might reach quite different conclusions if they compared peer workers with case managers who are graduate mental health professionals.

48 If peer workers and mental health professionals work together with a particular person, there are likely to be synergistic benefits, but there is no separate evidence to show that a peer worker is as effective as a professional case manager.

49 In my view, it is important that peer workers synergise with mental health professionals. The peer workers need mental health professionals in the team that can help them feel supported and not to feel traumatised. The presence of professionals also allows for some pastoral mentorship and supervision. They can help put things in perspective, and give peer workers the benefit of the more professional psychotherapeutic skills needed in such teams.

Leadership

50 In terms of leadership in each service, clinicians should get involved with leadership, and should receive leadership training. There has been a tradition in health systems that the doctors are assumed to be the natural leaders.[2] In my publications, I have referred to this as the "divine right of doctors to lead". In my view, however, doctors do not have any such

[2] See for example Rosen, A. Defining the role of the consultant psychiatrist in a public mental health service. Australian and New Zealand Journal of Psychiatry. 1998: 32:5, 612-616 and Rosen A, Callaly T. Interdisciplinary teamwork and leadership: issues for psychiatrists. Australasian Psychiatry 2005. Vol 13, 3 pps. 234-40.

divine right in contemporary services. They first need to be interested in and then trained in leadership, and supported in leadership roles.

51 We need a leadership group which includes clinicians and managers committed to leadership. We want clinicians to be interested in leadership, and among them, we want psychiatrists to be interested in leadership. However, just because you are a psychiatrist, that does not mean you are a natural leader or a trained leader. Good leadership requires aptitude, interest and motivation, and it requires training. No profession has a monopoly on good leadership. We should be aiming for an interdisciplinary leadership group for each regional service.

52 I note that Recommendation 6 (Lived Experience Workforce) proposed that the Victorian Government expand the consumer and family-carer lived experience peer workforces, and should enhance workplace supports for their practice. I repeat my comments about the lived experience workforce and the National Institute proposal above in relation to this recommendation - we have to make sure we get the balance right.

Recommendation 8: New approach for mental health investment

53 Recommendation 8 is that the Victorian Government should design and implement a new approach to mental health investment. The new approach would comprise a new levy or tax, and a dedicated capital investment fund for the mental health system.

54 I would also have expected a recommendation for a dedicated, recurrent budget. But there is a problem with budgets in mental health: money is allocated to mental health, and put in the budget, but ends up being spent elsewhere. This problem has occurred not only in Victoria and in New South Wales, but also in other states.

55 By way of background, all the CEOs of the NSW LHDs and their equivalents in some other states and territories have discretion to take money out of the mental health budget and use it for other purposes. That is the case even if you have a dedicated budget for mental health. The CEO can make decisions about where to allocate the money.

56 As a hypothetical example, in some LHDs, the CEOs may find that they are short of cars for clinicians in other disciplines like palliative care or oncology. In response, some CEOs may take resources for those vehicles, which were earmarked for mental health, and redirect them towards those other disciplines. The CEOs may then journal those resources back against mental health, so that it may appear as though they have been spent on mental health.

57 In my view, we should have legislation that says that each mental health service must have a discrete budget and regular auditing (say annually) of acquittals (expenditure).

Rather than looking at the budgets, someone needs to examine where the expenditure has occurred and how that spending has been acquitted.

58 There are two models for effecting regular audits. One way is to provide legislation to ensure that the budgets and acquittals are monitored and assessed regularly. The other way is to form a Mental Health Commission that holds the budget for mental health from the state. The Mental Health Commission would be responsible for the commissioning of expenditure for mental health. An example of this type of model is the Western Australian Mental Health Commission.

How Victoria's funding of community health has changed over recent years

59 From the inception of the National Mental Health Strategy in the 1990's, Victoria was the national leader in running distinct, evidence-based mental health teams. Mental health teams in Victoria that are evidence-based included the early intervention psychosis teams, CATT, ACT teams, the respite teams (known as PARCs in Victoria), as well as community mental health rehabilitation teams. The latter have now disappeared as a result of the NDIS.

60 In addition, many LHN services which had those distinct teams dismantled them, and have had generic teams established in their place. It is not clear why those teams were dismantled. In my view it had nothing to do with them being ineffective, although that may have been the pretext - they were not doing enough work or they were not seeing enough patients, in which case they could have been reviewed and revamped.

61 There is still a minority Victorian services that are national models of complementary evidence based teams. One example would be Alfred Health's mental health system The Alfred Health mental health system has all the above elements, but they have had to work hard to hang onto them. They also have an administration and a CEO who have supported the structure. That is, the Alfred Health management has seen the value in that culture of having distinct teams based on an evidence base that they know will be effective for a particular sub-population.

62 For more discussion of the financial costs associated with providing mental health services, see Gurr R, Rosen A et al, *Response to the Productivity Commission Mental Health Inquiry Draft Report*, Transforming Australia's Mental Health Service Systems, Submission No 919 to the Commonwealth Productivity Commission, *Mental Health*, 24 January 2020 <www.pc.gov.au> (***TAMHSS Response to the Productivity Commission Draft Report***). Attached to this statement and marked "AR-4" is a copy of this document.

63 In my view, if we are going to provide community mental health care properly and allow for crisis and review home visits, it is going to take time to travel to places and to travel

back. For example, it means that we cannot pool all the cars at the other end of the hospital. We cannot have a situation where the car pool is depleted and we cannot make a home visit.

64 Sometimes the problem is that the culture of a team slips into being sedentary. We need to have active-response not passive-response or sedentary teams. The home visiting component results in positive outcomes. All community mental health teams that have good outcomes have home visiting as a component. Therefore, it is important that we retain that component and develop it further.

65 In my view, some CEOs understand the need for differentiated mental health teams that have an evidence base. Those CEOs have kept the differentiated teams going, but that is the minority. The majority of CEOs in Victoria are under financial pressure and are encouraged to genericise their teams. Those genericised teams have no evidence base at all. They require everybody to do a bit of everything. One day you might work in a crisis team, one day you might work in an ACT team, and sometimes you might be sent to work at a respite PARC.

66 As to the differences between a crisis team and an ACT team:

(a) crisis teams are for acute situations; they try to keep people out of emergency and out of hospital. Crisis teams also make sure people receive intensive services at home while they're in crisis, and work with them and their families "on their own turf and terms";

(b) ACT teams are for those people living with severe, persistent and complex mental illnesses who require more long-term care. The ACT teams try to stabilise people without disrupting their lives by providing safe community treatment and support, as an alternative to the revolving door inpatient admissions, which would previously mean they were in hospital so often.

67 As to community residential respite centres, they ordinarily do not have locked doors, and sometimes people feel that they have more control of their lives by getting help there, rather than in an inpatient unit. In my view the Victorian community residential respite (PARC) centres are very good. A lot of good thought and good evidence-based planning went into the development of the Victorian facilities.

Recommendation 9: The Mental Health Implementation Office

68 Recommendation 9 is that the Victorian Government should establish a "Mental Health Implementation Office" (**Implementation Office**) to implement the Royal Commission's recommendations as set out in the Interim Report.

69 That Implementation Office sounds akin to a Mental Health Commission, which would complement the work of the Department of Health and Human Services' mental health reform unit. A continual reform-oriented Mental Health Commission could also work alongside the Mental Health Complaints Commissioner (**MHCC**), although the MHCC has a different focus. Complaints are very time-consuming, so the MHCC and the Mental Health Commission should be linked, but have separate functions and staff.

70 A Mental Health Commission should have an overview of the whole mental health system, and should use the trending of complaints to identify gaps in services, and areas where services are not effective. The Mental Health Commission should also have the overarching vision and trajectory of what goals the services need to achieve as part of mental health reform.

71 In my view, it has been more or less like a blood sport in Australia to keep depriving mental health of funds, by diverting them. As I have discussed above, one way to ensure adequate funding of mental health is to have a discrete mental health budget and regular auditing of both budgets, cash-flow and acquittals. The newest example of a jurisdictional reform-oriented commission is the Office for Mental Health and Wellbeing in the Australian Capital Territory. It is a mental health commission in everything but name, and its Coordinator General has an overview of the budget, although she does not *hold* the budget.

72 A Mental Health Commission would need to be at arm's length of government, so that it is free to make recommendations to government. But the Mental Health Commission would need to do that respectfully; it should work together with the Victorian Government.

73 A relevant model is the Western Australian Mental Health Commission, which is a *commissioning* commission. They hold the budgets for mental health, and they commission the services that work. That addresses the problem of needing dedicated funds for mental health.

74 For my views on the benefits and limitations of mental health commissions in the context of governance, see below at paragraphs 230 to 233.

75 For more information on mental health commissions, see:

(a) Lesley van Schoubroeck, "Western Australia's Mental Health Commission" (2012) 17(4) *Mental Health Review Journal* 229; and

(b) Sebastian Rosenberg and Alan Rosen, "It's Raining Mental Health Commissions: Prospects and Pitfalls in Driving Mental Health Reform" (2012) 20(2) *Australasian Psychiatry* 85.

Future trends

Future trends for the provision of mental health services over the coming decades

76 I anticipate some future trends in the provision of mental health services, three of which are discussed below:

(a) first, our workforce will need to be trained and well supervised in employing both micro- and macro-skills. Micro-skills are required for working with individuals in need and their families with both evidence based interventions and service delivery systems;

(b) second, there is a need to balance new office based digital technologies with in-person, home visiting and assertive outreach care in our service delivery systems, and

(c) third, we need to ensure that mental health professionals are well trained and supervised not only in these micro-skills, but in the macro-skills of being able to be competent and confident in working on the mental health of and with your local catchment or community. The macro level is about ensuring that staff have sufficient skills to work with and take responsibility for improving the mental health and wellbeing of the community. This entails competence in working effectively with service-user and family networks, public meetings, social movements, leadership networks, cultural minorities and whole communities, and communal crises and disasters.

More refined micro-interventions and service delivery systems

77 In my view, we need a well-trained clinical workforce, trained in micro-skills for evidence based interventions and therapies. These could include, for example:

(a) Dialectic Behaviour Therapy (**DBT**) (for people with borderline personalities);

(b) Cognitive Behavioural Therapy (**CBT**);

(c) Neurocognitive Remediation Training or Cognitive Remediation Therapy;

(d) Interpersonal Therapy (**IPT**); and

(e) Family Intervention Therapies (**FIT**).

78 All these interventions end in T, but there is another one that ends with T, and that's "*a cup of tea*". This belongs to evidence-based micro-skill required to run effective service delivery systems. The 'cup of tea' concept is about how a person is welcomed when they enter a facility, or how we can talk to somebody shoulder-to-shoulder in their own home. Just because you are a professional, does not mean you should take over and pull rank

in somebody else's home. The 'cup of tea' concept is about how you engage with people. If a person comes into your facility, you need to welcome them; and if you go to their home, you should allow them to set the etiquettes and house rules. We should reclaim the term "hospitality" in healthcare (rather than "hospitalisation"), much of which has been lost as technologies and health bureaucracies have taken over. Mental health workers should not use their assumed positions as powerful professionals, to take over all decision making, without consulting carefully with service-users and their families.

79 We need to draw a distinction between the *interventions* and the service delivery system or *vehicle* in which those interventions travel. The vehicle that a toolkit of interventions travels in may be an ACT team. The service delivery system is the vehicle that delivers the intervention. We need evidence-based interventions to be delivered in evidence-based service delivery systems.

80 We are developing micro-interventions and clinical service delivery systems that are far more refined. We start at the micro level with the most domestic context, by working with the individual and their family. Then we zoom out to another level, and look at how to surround those people with services and with at least a temporary bridging to an extended kinship or natural support network. A case manager can act as a substitute for supportive family to start with, if the person is living in isolation or at a distance from their accustomed supports. Then we zoom out another (macro) level, and look at how to build in other communal resources as well. For more information on the distinction between the micro level and macro level of mental health services, see Table 2 in Alan Rosen, "The Community Psychiatrist of the Future" (2006) 19 *Current Opinion in Psychiatry* 380, 384, and Rosen A, Gill N, Salvador-Carulla L, and Figure 1 and Table 3, The Future of Community Psychiatry and Community Mental Health, Current Opinion in Psychiatry, June 2020.

81 We are building a mental health eco-system. We need to 'go ever wider' in context, or take the system that we work in much *wider*. Meaning means a lot in mental health. Our treatments can result in huge improvement, and every now and then, even cure a person. But there is a healing aspect of mental health that includes factors like context: eg. "living in the community is healing in a way that hospital is not" (Harding C, Keynote Lecture, Book of Proceedings, TheMHS Conference Sydney, 1997), compassion, purpose and relating. Those are all healing factors. Aboriginal people and people who come from traditional communities know this. They know that you need to work "two ways" (after Professor Sir Mason Durie, the first and most senior Maori academic psychiatrist in New Zealand- Durie M, foreword: in Nia-Nia W et al, Collaborative & Indigenous Mental Health Therapy, Routledge 2017): at the clinical and technical level, and at the level of purpose and meaning. For more on approaches to Aboriginal mental health, see AR-4 pages 20-22.

82 The macro level is also about how to the work with extended families, and how to work with *groups* of families, or multiple family groups.

83 On that, there is a distinction between family groups and groups of families. When people cannot solve problems with severe mental illness in their households, they may become isolated. It might be helpful for them to meet other families with whom they can exchange mutual support and brainstorm solutions. Working with groups of families helps those families widen their community. Even after we stop doing therapy with them, these groups of families can keep meeting within the community they have formed.

84 Community building is part of working on social determinants. Many of our clients easily drop out of the workforce, become poor, cannot afford their rent or medication, and then become florid, get involved with drug cultures, and end up homeless or in hospital again. So our mental health services leaders need to be centrally part of the planning and provision of mental health and mental illness services in the catchment area or community.

Balancing new technologies with in-person care

85 We need to find a balance between the use of new technological developments, and the use of in-person services. I note that the technical changes are mainly around digital substitutes for in-person mental health care such as telepsychiatry and telehealth. Our use of e-health strategies is also increasing (as an example, these are strategies where a person accesses a program or an app, and it tells you what to do to develop a skill such as mindfulness). There will be a human voice in there somewhere, but the app does not require the attention of an actual human being in real time. These apps can also perform assessments and point people in the direction of certain interventions.

86 However, there are problems with the interfaces of some of these new technologies. Often these systems work by using artificial intelligence on the basis of pre-programmed computerised algorithms. For example, an app may arrange a self-rating of a person to determine how suicidal that person is. If that person self-rates as highly suicidal, then the computer is programmed to "escalate" that person to an in-person service, or it may send an email to a local service. But if that service is depleted and overwhelmed because it has been underfunded, or if that service does not have coherent teams, then nobody might read or respond to the email. The computer does not know whether the service has responded or not, or whether the service has responded in a humane way. If there are going to be e-health systems that escalate individuals with severe disorders, then there needs to be someone at the services picking up the severity ratings and making sure that those people are referred in person, by a person, to another person in the intended receptor service.

87 With tele-psychiatry systems and telehealth, there are limitations. It is not possible to do a full physical examination over telehealth, and some of the contextual cues are lost or missed if the clinician is not seeing them in person. Seeing people for many months or years only by telehealth is not as effective as seeing them by telehealth plus doing at least part of the initial assessment and occasional follow-up session in-person. For example, you might see someone in person for an assessment or for a yearly review, and in between connect with them over telehealth. It is best if the service finds a way to see them in person every now and then. This is called "Hybrid Care" practice: Yellowlees P & Shore J, Telepsychiatry & Health Technologies, Ch 8, APA Press, 2018.

88 There is contemporary evidence regarding telehealth systems. We have had to rely on telehealth both for the bushfires and now for the COVID-19 response. With COVID-19, you can see that there is a greater necessity for such systems. With the bushfires, they were brought in as a major initiative from our College of Psychiatrists and from the psychologists. That meant that the professionals had the convenience of not travelling to the site. But it also made the help seem distant and temporary, and it replaced familiar local mental health workers. We had lost many familiar local mental health workers, even before the fires, because the country areas have suffered most from the process that I mentioned above (see paragraphs 54 to 56) of money being siphoned out of a local mental health budget for other purposes.

89 The state and Commonwealth governments could have taken the bushfires as an opportunity to work with the states to bolster and revitalise the local mental health services in the bushfire areas on a pilot basis. Instead, most states had to rely almost entirely (not completely) on extraneous and transiently funded telehealth services. The majority of additional services that the Government has offered to those areas have been telehealth or tele-psychiatry services.

90 How do we determine what the right balance is between telehealth services and in-person services? The modern way of thinking about it is to consider the severity of a person's disorder. Modelling evidence demonstrates that the more severe and disabling a person's disorder, the more they will need in-person services: they will need interdisciplinary teamwork assertive outreach and at least a hybrid in-person with digitally augmentation approach to care (Rosen A McGorry P Herrman H et al, 2020, Call for a comprehensive National Mental Health Plan to respond to the novel coronavirus (COVID-19) at paragraph 289; Atkinson J-A, Hickie I, et al Covid 19 Pandemic Response: every life matters. Brain & Mind Centre, University of Sydney, 2020). In-person services can engage a person and get them out of their bedroom, so that they will attend for interventions or day centres, and so that they will experience social inclusion and have a sense of identity.

91 A person with a severe and disabling disorder does not need just one therapist who can teleconference. Instead, the person needs a team with a division of labour. For example, in a team, there should be a psychiatrist who performs clinical assessments and reviews, an occupational therapist who works on the person's activity and employment, social workers who make sure the family is intact and not abusive, and a psychologist who provides evidence based interventions. For more information about hybrid approaches, see Hybrid care approach (Yellowlees P & Shore J, Telepsychiatry & Health Technologies, Ch 8, APA Press, 2018).

92 For people with more mild disorders, we can rely more on technologies such as e-health, telehealth or tele-psychiatry, particularly when the person is young or comfortable with computers and IT. Moreover, some people prefer connecting through telehealth. For example, some people who are on the autism spectrum or who are shy may prefer talking with the use of technology than to real people (though in my view most people prefer a connection with real people).

93 In finding the right balance between telehealth services and in-person services, we can draw on both the experiential expertise of clinicians, and on the experiences of service-users and their families.

94 Anecdotally, there are reports that service users are currently feeling a lack of personal contact, even with their peer workers. In part, the causes of insufficient face-to-face personal contact with service-users include: loss of evidence-based management and work culture, inconsistent leadership and unhelpful senior role-modelling, and depletion of resources with increasing demand. Peer workers are following the lead of the clinicians and sticking to telehealth, even though the general consensus from peer workers seems to be that they do not feel comfortable limiting their contact with consumers to telehealth. However, that is what many peer workers are being told to do (Peer Workforce Survey, Being NSW, 2019).

95 We can also rely on evidence to help us find the right balance between telehealth services and in-person services. An example of work being undertaken to gather evidence on this question is service demand modelling work at the University of Sydney's Brain and Mind Centre. Data from international and national sources is being used to model (not predict) the possible range of expected delayed surges in demand for mental health services and appropriate mental health service responses in the wake COVID-19. The work is ongoing.

96 As part of this work, we are finding that if we try to contain surges in demand, and particularly the surge caused by relapses of those who have severe and persistent mental illnesses and high-risk suicidality, through the use of telehealth alone, we will not make much impact on that surge. However, if we provide in-person interdisciplinary team work with a division of labour, the modelling shows that you can contain and flatten the curve

of demand for mental health services. I discuss the expected surges in demand following COVID-19 at paragraphs 283 to 291.

97 For more information on the balanced use of e-health, telehealth in balance with in-person and mobile outreach care, see Gurr R, Rosen A, et al, *TAMHSS Submission to the Productivity Commission*, above at paragraph 81.

Impact of future trends on different groups within the community

98 New technologies are offering some promise to rural and remote mental health. I work in Aboriginal mental health and have worked in remote Aboriginal communities on a sessional basis for most of my career. Technology is important to those communities. Often Aboriginal communities and remote communities are familiar with teleconferencing, and have used it in various ways for different disciplines, such as health and education.

99 But, as I have said, we cannot just rely on technologies alone. We need to review services in person as necessary and whenever possible. If we are going to shape the future of mental healthcare ecosystems, we need to achieve a balance between in-person care and telehealth. We also need to attend to and be well trained in both the micro-strategies and the macro-strategies of community mental health care (see Gurr R, Rosen A, et al cited at paragraph 97 and Rosen A, Gill N, and Salvador-Carulla L, Future of Community Psychiatry and Future Community Mental Health, Current Opinion in Psychiatry, June 2020).

Responding to future trends in the provision of mental health services

100 To respond to the future trajectories identified above, the first thing we need to do is support our workforce and attend to its skills, training and supervision. As stated above, the mental health workforce also needs regular mentorship to look after its pastoral needs and to retain its skilled workers.

101 The second thing we need to do is renew our national standards. There are two sets of standards, one of which is the National Standards for Mental Health Services, which have not been renewed for a long time. I appreciate that this is not the job of this Royal Commission, but given those standards are used for accreditation of each of the LHDs, they ought to be revised and updated.

102 The second set of standards is the National practice standards for the mental health workforce. The standards provide guidance for the workforce about what workers in particular should be doing and outline the values, attitudes, knowledge and skills required of all workers. This set of standards is also out of date, and needs revision.

Community-based model

Best-practice examples of community-based mental health care

103 In relation to best-practice examples of community-based mental health care, I have already discussed the three levels within mental health HITH schemes. This model could be used to respond during the COVID-19 pandemic, but it may also give us an opportunity to partner inpatient units with parallel HITH schemes as an alternative to building new beds. It would be advisable to run pilot studies to establish that these programs are both useful, and will act as an effective substitute for many beds after the COVID era. However, HITH schemes cannot replace all inpatient mental health services, because a minority of service-users will require inpatient services, for reasons of safety and security, and for acute neuropsychiatric assessment.

104 In my view, we are also moving towards having services that systematically facilitate human rights. The first human right that people have is freedom. Just as we noted above that community living is inherently healing, freedom is therapeutic. However, freedom is not absolute. The United Nations Convention on the Rights of Persons with Disabilities (**UNCRPD**) recommended in the direction of absolutes, and that there should not be any involuntary care. I do not think that is realistic, but I agree that we should be working along that trajectory. We should be aiming to have as much freedom and choice and control in the hands of service-users as possible. To do that, Victoria needs to utilise its *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Charter of Human Rights**).

105 There is strong emerging evidence about how you can reduce seclusion and restraint (eg Wright M, Chief Psychiatrist, NSW Ministry of Health Inquiry into Seclusion & Restraint, 2017-2018; Brown P, Foxlewin B et al, Australian Capital Territory MHS, 2013 and the sources listed in paragraph 108 below). In my view, the fact that seclusion and restraint are used is not a discrete issue in itself. Rather, in my view it is part or a subset of the spectrum of human rights that we should be implementing.

106 To ensure the human rights of mental health system users, we need to have more voluntary services of all kinds, and fewer involuntarily services. As mentioned above, I do not think we will be able to eliminate involuntary services altogether, and for the minority we will need mental health inpatient units. But if we embrace voluntary services, there will be less pressure on inpatient units, and eventually fewer beds, as we develop our skills. There are evidence-based skills for interacting with people in ways that soothe emotions and aggression, elicit co-operation and create therapeutic alliances. That applies for people with mild to moderate conditions, all the way through to those with severe psychiatric or behavioural disabilities.

107 For instance, there might be a substantial proportion of the people in a particular intake referred into an ACT team on CTOs. But if your ACT team works at it, then over time (and it might take several years), you will bring those people to the point where they will be working with you on a voluntary basis, because you have got to know them so well. Those people will know that you believe in them and encourage them.

108 For more information on the human rights agenda, see:

(a) Rosen A, Rosen T, and McGorry P, The Human Rights of People with Severe and Persistent Mental Illness: Can Conflicts between Dominant and Non-Dominant Paradigms Be Reconciled?" in Michael Dudley, Derrick Silove and Fran Gale (eds), *Mental Health and Human Rights: Vision, Praxis, and Courage* (Oxford University Press, 2012) 297; and

(b) Mezzina R, Rosen A et al, "The Practice of Freedom: Human Rights and the Global Mental Health Agenda" in A Javed and K N Fountoulakis (eds), *Advances in Psychiatry* (Springer, 2019) 483.

Core features that make community care effective

109 One common feature of effective community care is having an active response rather than a passive response. Active response means being prepared to get out of your office. It means not sitting in your cubicle, just seeing one person after another, but reviewing them in context, in their own setting. Home visiting is part of that.

110 What we know is we can synergise medication or other physical treatments with psychosocial interventions. Effective psychosocial interventions include educating the whole family, imparting communication and brainstorming skills to groups of families, placing people in stable housing with support and putting people into individual placement and support programs to get them into work or into a social co-operative. We also need to ensure proper care for their physical ailments and vulnerabilities, especially attending to the need to curb smoking, and the use of alcohol and other drugs. We need psychosocial strategies as well as physical and chemical strategies.

Key barriers to the delivery of effective community-based care

111 The key barrier to the human rights approach is that some clinicians are taught to think that mentally ill people need to be controlled. Their reasoning is that you need to keep some mentally ill people under your thumb, because they will never learn any self-control. However, I think that the majority *can* take control of their own lives with encouragement, rebuilding confidence, life skills, cognitive remediation, and brain re-regulation for others suffering still from past traumas. People learn to be self-determining as part of a recovery agenda. We are seeing more and more indications that freedom and choice are healing

in themselves, just as community living is healing in itself. Recovery can involve lifelong learning, growing and developing throughout life, as the rest of us do. We should be entitled to think that we are lifelong learners, and that we can grow and develop throughout life.

112 There are obstacles to that conception of recovery. Some people think, "*Oh, I'm getting people to recover by being patronising to them and controlling them.*" However, that is an outdated approach to conducting mental health services.

113 I can draw an analogy between people's long-term healing and our current response to COVID-19. We are encouraging everybody to isolate themselves, and it is much easier to do that if you try to capture people's and the community's imaginations and commitment. It is easier to convince people to self-isolate if we can show them that there is a purpose and we can reframe it in terms of contributing to the community. Volunteerism and reward both work much better than threats and punishment.

Ways of supporting suicide prevention efforts

114 To support suicide prevention efforts, Victoria needs to stop genericising its services. I have touched on this above at paragraphs 59, 60 and 65. In Victoria, in genericized teams, mental health professionals are all expected to do a bit of everything without developing particular skills in or about anything.

115 People do learn particular evidence based skills in dedicated teams (such as crisis or ACT teams), and they also develop a commitment to the methods involved. Properly resourced 24/7 crisis teams are often well trained in and organised for suicide prevention or self-harm repetition, including DBT. Because of this, they can effectively substitute for each other when one of them goes on holidays or gets sick.

116 However, if you ask people to do a bit of everything, then they will be spread too thin. They fail to develop a relationship with the people they are seeing, because they see them infrequently or intermittently. With smaller, specialised services, the service user gets to know a small number of professionals who cover each other, and learns to work with a little sub-team. That is why Victoria should stop genericising its services.

117 Another way to support suicide prevention efforts is to promote a culture that prioritises quality mental healthcare over saving money. Currently, some managers and CEOs have lost the idea of what the culture of a good mental health service is. When that happens, management starts to see saving money as the top priority, not the quality of the service. However, we have also seen in Victoria that there are CEOs and directors of mental health services who have supported their differentiated teams (for example, the Alfred

Mental Health Service). Those managers have also been subjected to monetary pressures, but they have seen the sense in retaining differentiated services.

Designing mental health services to meet diverse needs within the community without creating further fragmentation of services

Dilemma between specialisation and generalisation

118 There is a dilemma between the specialisation and generalisation of services. This is because in order to have evidence-based, reliable outcomes, you sometimes need specific evidence-based fidelity criteria for the team to meet, and the team needs to be well trained in working together. If you train to that method, and if you then review them by the evidence-based fidelity criteria, then you are more assured of an evidence-based, positive outcome. For more on the dilemma between specialisation and generalisation, see Alan Rosen, Helen Killaspy and Carol Harvey, "Specialisation and Marginalisation: How the Assertive Community Treatment Debate Affects Individuals with Complex Mental Health Needs" (2013) 37 *The Psychiatrist* 345.

119 The effectiveness of specialist teams working to evidence-based fidelity criteria applies to the evidence on ACT teams and on crisis teams. These teams do not necessarily stay working the same way, but the fidelity criteria which guide their team members keep developing as the evidence base keeps developing.

120 Although we have an evidence-base in relation to specialist crisis teams, ACT, residential respite and early intervention in psychosis teams, there is no evidence base for generic mental health teams (that is, mental health teams that try to do a bit of everything).

Factors affecting the decision to create a specialist team

121 It is not practicable, however, to have a specialist team in everything. Whether or not you should have a specialist team for a particular group depends on three things: first, demography; second, the evidence base; and third, the availability of specialist teams at different levels.

122 First, the choice to have a specialist team depends on demography. If you have a demography that contains many homeless people, for example, then you might want to set up a particular homeless team. Often an ACT team works well with homeless people. With, for example, gender diversity and suicide, if you had a large cluster of people in that category in your area, then you could set up a specialist team. However, you could also argue that *every* team should know how to work with that combination in a way that is both respectful, encouraging, constructive and effective. A team which only focusses on suicide may also contribute to negative labelling and stigma.

123 Second, the choice to have a specialist team depends on whether there is an evidence base for working with a particular population. For example, in relation to Indigenous mental health teams (like every other human service for Indigenous people), the evidence is now becoming strong that they need to be community controlled. The mental health teams that work with Indigenous people need to have Indigenous people at least on the Board, and ideally, Indigenous people in the team whom the Indigenous community can recognise as people of their own culture.

124 The benefit of having services in an Indigenous community that are run by Indigenous people applies not only to mental health services or physical health services, but to all community services (such as education, fire and police). The research on this has been undertaken by mental health academics: see, for example, Michael J Chandler and Christopher E Lalonde, "Cultural Continuity as a Moderator of Suicide Risk among Canada's First Nations" in L Kirmayer and G Valaskakis (eds), *The Mental Health of Canadian Aboriginal Peoples: Transformations, Identity, and Community* (University of British Columbia Press, not yet published).

125 The third thing to consider when deciding whether to create a specialist team is the availability of specialist teams at different levels of magnitude. There might be a tertiary service, regional service, or local service that will do the job.

126 The primary health level of mental health is the training that specific general practices and primary healthcare workers have in mental health. Primary care level multidisciplinary counselling or mental health mobile teams are being developed in the UK, New Zealand and Australia (see IAPT, PHO and YESS models in Rosen et al, 2020). At the next level of magnitude up, there are the specialist mental health workers, both in the community and in the hospital. At the next level are the tertiary services. Tertiary services exist where there would be a critical mass of consumers across a region or a state, but where there may not be a critical mass of consumers in a local area. If there is not a critical mass to work with reliably at a local level, then you should be setting up a tertiary service that will provide care at a regional, city-wide or state-wide level.

127 An example of a specialized state-wide and regional service is the transcultural Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (**STARTTS**) in NSW. Victoria has a similar torture and trauma transcultural service, the Victorian Foundation for Survivors of Torture (Foundation House). That service has outposts with other regional services and has expertise working with traumatised transcultural communities. That includes refugees and asylum seekers, and also the communities affected by genocide and trauma.

Issues in which all staff must receive training

128 There are certain issues in which we need to train all staff. For example, issues we need to train all staff in include cultural issues (such as indigenous cultural safety), sexuality, human rights, domestic violence, gender and child protection.

129 We then need to decide what training should be reserved only for specialist teams. For example, do we provide LGBTI training and domestic violence training for all our teams, as well as transcultural training and Indigenous cultural safety training, or just to specialist teams? For more information on specialization of teamwork, see Rosen, Killaspy and Harvey, above at paragraph 118.

Supporting people to self-manage their mental illness in the community

Shared decision-making

130 As part of a recovery agenda, people should learn to recognise their early warnings signs, know when they need to get treatment, and contact their doctors or their clinicians for treatment when they need it.

131 To assist the recovery agenda, people can also use instruments like "living wills". These do not necessarily need to be legal or formal documents; they can be negotiated documents. In a living will, a person might say, "*When I get to this state, or if I don't know what I'm doing, then please do the following*" and the instruction might be "*Please put me on particular medication X*" or "*This is who I need to be put in touch with."* Taking control in this way can avoid involuntary treatment and orders. It keeps a person feeling like they are in the driver's seat of their own life, even if they know there will be times when they are not aware of whether their actions will be harmful to them, to their livelihood or to their reputation.

132 We know about early warning signs and have lists of those signs. A person can negotiate what those early warning signs are with their family or with their loved one. The case manager or the care co-ordinator can draw up a list for them and make sure that everybody has a copy of it (with the permission of the consumer).

133 There are programs to help people self-manage their illnesses. These programs have been developed through researchers at Boston University's Center for Psychiatric Rehabilitation, Dr Kim Mueser and Dr Marianne Farkas. Through these programs, people can learn techniques and methods of assisted or supported decision-making. For instance, the consumer movement, through Pat Deegan in Massachusetts, came up with a shared decision-making model where both the service user and the service provider negotiate a joint plan on a computer program. For more information on this model of

shared decision-making, see Patricia E Deegan et al, "Best Practices: A Program to Support Shared Decision Making in an Outpatient Psychiatric Medication Clinic" (2008) 59(6) *Psychiatric Services* 603.

134 I understand that the UN, through the UNCRPD, would prefer that people are supported to make their own decisions. For more on the UNCRPD, see Mezzina, Rosen et al, above at paragraph 108(b).

135 However, in my view, it depends on the person; there should be a spectrum. Some people need to work out a plan together with their care co-ordinator; other people just need some support to clarify what they want, and some people are capable of negotiating. Many more people are capable of negotiating a care plan than the number whom we systemically approach to do so. We have much more involuntary care in Anglo countries than is necessary because we do not employ the evidence based tools that we already have regularly or systemically. For further information on living wills and self-determination, see Rosen, Rosen and McGorry, above at paragraph 108(a).

Supporting families of people with mental illness

136 I have worked a lot with families of people with mental illness. I have completed formal family therapy training, and I have recently done an open dialogue training, which is a Finnish method of working with families of people with a first episode of severe mental illness. I am therefore aware of the different models, only a few of which have rigorous evidence for their effectiveness.

137 In relation to people with severe and complex mental illness, there are four ways of working with families: first, facilitating family self-help groups; secondly, involving families in the running of services; thirdly, using evidence-based family interventions; and fourthly, hiring family peer workers.

Family self-help groups

138 First, families should be encouraged to form self-help groups. Families of people with mental illness tend to become isolated. They need to meet with other families that are in a similar situation, rather than burrowing away because of the embarrassment or the shunning that they get even from within their own extended family.

Involvement of families in the management of services

139 Second, families are very valuable in helping to run services. You get a lot back from the family movement if you involve them in an advisory role or in the direction of services (for example, in steering committees or advisory committees). If you have an advisory committee of service users and families, families in particular will tell you that they feel a

bit helpless about trying to shift the possibly life-long mental illness that their loved one has. They say that they feel like they are achieving more by helping the service to improve, so that it will improve for other individuals and their families. They feel as if they are doing something that is gaining a foothold in the improvement of services.

Evidence-based family therapies

140 Third, there are specific therapies that have a very good track record in evidence. For example, there is a way of working with particular families called psychoeducation and communication skills. The evidence says that it decreases relapses and improves communication in families. Improved communication means that there is less of a hot-house atmosphere, which means there is less of what is referred to as "expressed emotion". Instead, people learn how to communicate with each other clearly, without blaming each other or thinking the illness defines the person. People also learn how to give positive feedback, and how to give negative feedback. This is followed by learning to do effective problem solving. Rather than internalizing: "*This is a flaw within you*," people learn to say, "*This is something between us that we can solve*."

141 There is a parallel program which has achieved good outcomes called Multiple-Family Groups. The person who has led the highest grade evidence study in the world on Multiple-Family Groups is William McFarlane, of New York State. He was one of a group of researchers who published a large-scale randomised study in one of the top journals that requires the highest level of psychiatric evidence in the world, the *Archives of General Psychiatry* (now called *JAMA Psychiatry*).

142 In Multiple-Family Group treatment, you get a group of families together (usually with the service user involved) and you workshop their issues. Families learn communication skills together, and they learn about the disorder together. They also learn how to negotiate better solutions.

143 For example, take the situation where somebody has a severe mental illness and is keeping the rest of the family up all night (for example, by listening to loud music), and everyone else in the family has to get up in the morning to go to work or school. The person with the disorder may sleep during the day, while others are just sleepy at work or school. How do you negotiate around that so that everybody gets some sleep?

144 The families brainstorm that and do some problem solving. They then decide as a group of families which strategy to try. The families all go home and try that strategy for a couple of weeks and see how it works. Then they come back and report to each other.

145 Multiple-Family Groups are facilitated on a regular basis. It produces good outcomes and solves these practical problems for families. It helps with settling down the disorder

systematically and functionally. An interesting thing that comes out of these sorts of programs is that even after you stop running the course, the families will often continue to meet together after the final session. They form a community — an intentional community.

146 For more on Multiple-Family Groups, see William R McFarlane et al, "Multiple-Family Groups and Psychoeducation in the Treatment of Schizophrenia" (1995) 52(8) *Archives of General Psychiatry* 679.

Family peer workers

147 There should also be family peer workers who work with the family interventions that I have listed. Family members can develop expertise in family psychoeducation and skills-based trainings in Multiple-Family Groups. In my view, some of the best facilitators are family peer workers, if they learn those skills.

Making specialist mental health expertise available to general practitioners

148 There is emerging evidence of how best to make specialist mental health expertise available to GPs. I will discuss three models for making specialist expertise available to clinicians working in general practice: consultation services; shared care with GPs; and graduate psychologists or interdisciplinary teams delivering psychotherapy under group supervision. I note that all the models need some further evidence.

Consultation services

149 The first model involves experts running a consultation service to GPs. This is sometimes seen in rural and remote centres where GPs do not have a specialist to call on, both by telehealth and in person. The GP will have the opportunity to meet with a psychiatrist, an experienced clinical psychologist or somebody who can help them with everyday mental health problems.

150 For remote areas, this model has some potential, because you could work with whole groups of GPs via a case teleconference on a regular basis.

151 I see this consultation model starting to happen with some groups of GPs.. For example, I have seen it happening with some Royal Flying Doctor Service (**RFDS**) teams, who employ a small team of mental health workers, as well as Aboriginal Medical Services (**AMSs**).

Shared care with GPs

152 The second model is that of shared care, where mental health experts do assessments with GPs. In the early 2000s, there was a program funded by the Commonwealth called the Integrated Care Program. There were three sites for the program: one in Far West New South Wales (for which I wrote the proposal), one in Melbourne, and one in Wollongong.

153 These were national projects that provided money for mental health professionals who were experts in their field to come and do assessments with GPs. The professionals were also funded to do some consultation with other agencies that had many people with mental illness coming through as clients, such as Lifeline and Centrelink.

154 The Integrated Care Program used a "shifted outpatient" model, which is one model of shared care. In this model, the psychiatrist (in this case, I was one of the psychiatrists) would go to a general practice and do an assessment with somebody whom the GP was worried about, but whom they were uneasy about referring into a mental health service. The GP might believe that the person could do better in the general practice. The psychiatrist would see the person with the GP, write a report and provide a plan. Usually, the psychiatrist would never see that person again, but the GP would ring the psychiatrist from time to time, either to let them know what was going on, or to ask a supplementary question. Usually, the person would not be referred into the mental health service.

155 There is literature on psychiatrists doing shared care with GPs in the GP's rooms, and this was part of the Integrated Care Program and evaluation: see Perkins DA, Roberts R, Sanders T, Rosen A, Sanders T, Roberts R et al. Far West Area Health Service mental health integration project: model for rural Australia? (2006) 14(3) *The Australian Journal of Rural Health* 105).

156 A third model for making mental health expertise available to clinicians in general practice is the delivery of psychotherapy. This model is best suited for treating people who have high-prevalence disorders like anxiety or depression. Often, a person will need some psychotherapy but the GPs in the community do not have not the time to deliver it.

157 A program called Improving Access to Psychological Therapies (**IAPT**) was developed in England in 2008. It was started by an economist, Richard Layard, in discussion with Gordon Brown, who was then UK Prime Minister. They developed it on the basis of an alliance between politics and health economics.

158 IAPT is an initiative which provides makes use of graduate psychologists to provide psychological therapies such as CBT to people with disorders that are common in the community in general practice under supervision. IAPT makes use of supervision

pyramids. A group of three or four graduate psychologists in general practice are supervised by one supervisor. Then there is a supervisor over several supervisors, and so on.

159 At the time, Richard Layard was a professor at the London School of Economics. He said, "*As an economist, I learnt two things about what is cost-effective in mental health. First, you work as a team: you make sure that everyone provides team support, team input and team learning. Secondly, you have a very tight supervision system*." That is why IAPT makes use of the supervision pyramid, and why it is still working.

160 IAPT, however, does not necessarily reach down to all the people who might need it most and are in the greatest crisis, because those people do not access it as much. This is a problem in mental health: the middle classes know how to access services, but people who are struggling with poverty and unemployment find it hard to find the resources to seek help.

161 Another system has now developed in New Zealand initiated by Dr David Codyre. Dr Codyre's system relies on three levels of care. The first level is psychotherapy or formal counselling, the second level is cultural coaching (particularly for people who are from indigenous communities or cultural communities), and the third level involves peer support workers. They form one team which can provide peer supervision and support, and the team is funded by Primary Health Organisations (**PHO's**), based in general practices, and often delivered by telehealth.

162 There are also a range of similar methods that have developed in the United States, as well as a program in Sydney called the Youth Enhanced Support Service (**YESS**), which is a mental health outreach service for young people. It is funded through the PHNs. In YESS, mental health teams, each comprising a psychiatrist and other mental health professionals, work directly with general practices to do low-key work with young people. An adult version of YESS is currently being developed.

Strengths and limitations of service "hubs"

Strengths of the service hub model

163 The first strength of the service hub scheme is that it could help to address the missing middle in the mental health system (for more on the missing middle, see above at paragraph 29). I believe that the authors of the service hub model envisioned it as a practical service that would particularly serve the missing middle. The service hub would provide assertive mobile home based care for people with moderate severity disorders.

164 The second strength of the service hub model is that it would be one way to address the funding issues that currently impact community mental health services, by stopping the diversion of public mental health funding for other purposes.

165 The third strength of the service hub model is that it would help reinstate some community mental health teams within regional centres. These teams would provide evidence-based work and apply evidence-based models. The service hubs would also allow for specialisation, including having an element that does crisis work, and an element that does a form of ACT.

Caveats for the service hub model

166 One caveat in relation to the service hub model is that it requires the development of an evidence base, as well as being easily accessible, welcoming, culturally safe and congenial. Each component of a service hub must apply components each with an existing evidence base (such as offering seven day and night home visits and family interventions for individuals in crisis), then evaluate the effectiveness of their programs, workforce and workers against that evidence base. A relevant model is mental health crisis in combination with continuity of care teams: see Rosen et al, 'Integration of the crisis resolution function within community mental health teams' in Johnson et al (eds), *Crisis Resolution and Home Treatment in Mental Health* (Cambridge University Press, 2009). This model may be more low-key and more family work intensive for the 'missing middle' than for those with severe mental illnesses, but still meets crisis team fidelity criteria with seven day and evening home visiting outreach capability. This requires sufficient resources for cars and enough staff with adequate time to do home visits in and out of office hours. If there is no out of hours capability, you will not get to work with many working or studying families. Out of hours is when you are likely to catch them at home.

167 The second caveat I suggest for the service hub model is that it should not just become another triage service. We do not need another service that will triage people and pass them on to another mental health team or hospital. What we need are services in the community, with familiar faces, that can intervene with their local community. These teams should say, "*The buck stops here with us. We'll make sure that you get the care you need*."

Improving people's ability to navigate to the right mental health care, treatment or support for their needs

Gaps caused by disinvestment in community health

168 In my view, the real gaps in community mental health services started to emerge when the CEOs of Local Health Networks decided to take money out of them and use it to pay

for the overspend and shortfall in other often procedural services. This disinvestment in community mental health meant that people no longer had case managers or care co-ordinators. If community mental health services had service users needing ongoing case management, the services were told to keep those people only in the very short term, and then to send them back to primary health care.

169 The disinvestment also led to people sometimes being put on Community Treatment Orders (**CTOs**) so that case workers could hang onto them when they needed ongoing care. For example, a care co-ordinator might be told, "*You have to let that person go back to their GP*," even though the person was still in need of continuing care and advice. The care co-ordinator might think, "*One way of keeping the person is if I have them on a CTO; then I can actually care for and watch out for them*."

170 This use of CTOs was sometimes done with goodwill. However, it is still an abrogation of human rights and contradictory to put somebody on an involuntary order to be able to provide them with the least restrictive care. The least restrictive care would usually be good care co-ordination on a voluntary basis after an acute psychiatric episode or episode of suicidality.

Navigation plus services in the community

171 We need care navigation plus constructive services in the community. That means we need a sufficient number of clinicians and support workers and need them to work together with a sufficient number of care co-ordinators.

172 Because we lost case managers, care co-ordinators and a critical mass of staff, we had to pass people on very quickly. There used to be Partners in Recovery programs (**PIRs**). The PIRs used to establish co-ordination teams, which would help people to bring all the fragmented parts of the system together. However, some agencies could never find time to meet with the sometimes inexpert staff working for PIR's, nor to answer their calls, especially GPs and psychiatrists. The PIRs were eventually eclipsed by the PHNs. There then started to be layers of co-ordinators, but without anyone who would actually stick by people and do the active work with them.

173 Care co-ordination is best done by somebody who will see a person through their entire episodes (if they have an episodic condition), or throughout their long-term care (if they have a persistent condition), and who knows their early warning signs. A care co-ordinator provides the person not only with navigation, but also with coaching, shoulder-to-shoulder advice and a number of different interventions that may help over time.

174 The care co-ordinator should also get to know the person well. That means that the person will trust their care co-ordinator to help them when they are in a psychotic episode,

rather than shying away because they are feeling paranoid about everybody. That person will sometimes trust a care co-ordinator whom they know well and who will try hard to get the person what they want, whether that's keeping them out of hospital or getting them into a respite centre.

175 We need to have a person's care co-ordinator to help the person to organise and coordinate the interventions in the same team. Non-governmental organisations (**NGOs**) can help by being partners of that interdisciplinary team in providing the range of different interventions required.

Travel agents, travel companions and travel guides

176 We need care co-ordination, but what we do not need is a navigator who navigates and does nothing else. That would take us back to the old "travel agent" model of case management. In this model, there are three types of care co-ordinators: the travel agent, the travel companion, and the travel guide (Diamond R & Kanter J, 1980s).

177 The travel *agent* sits behind a desk and offers you leaflets. Like a travel agent, this essentially sedentary or passive brokerage type of case manager says, "*Don't worry if you don't like any of these brochures, because I can give you lots of other brochures!*" They are basically a broker of services.

178 The travel *companion* is prepared to travel with you and go with you on your journey. They do not have any more expertise than you do, but they will be a loyal companion. Some services, particularly support services, provide very good "travel companion" services. These are often peer support services, which help by encouraging people and saying, "*I've been through that myself.*" The services are helpful, but they do not treat or directly address the person's disorder.

179 The travel *guide* is somebody who has been on the journey many times before. They do have expertise in that they know all the most scenic routes, and they know how not to fall into the chasms. The travel guide can reliably say that you are going to arrive, where and when you are supposed to arrive, and get you there safely.

180 What we need is more "travel guide" type care coordinators and mental health workers in mental health services. Whenever possible, we need them to be co-located with, and in the same team as, the travel companions. The NDIS could fruitfully contribute financially to these well-tested, cost-effective, integrated clinical treatment and functional support systems for individuals with severe and complex mental illnesses. It is this type of model that I, with others, were asked to prepare over the last few years for the Commonwealth Minister for Health, with costings: see Alan Rosen et al, above at paragraph 34.

Treating children and adolescents with integrated mental health and AOD services

181 In the US and elsewhere, there are separate crisis teams and ACT teams for children and adolescents. The models have been developed specifically for young people. In Australia we generally do not have separate crisis or assertive mobile teams for young people, the few exceptions including YESS teams (see previously at paragraph 162).

182 In my view, the major problem for our treatment of children with drug and alcohol problems is that most child and adolescent teams are sedentary. They tend to develop a culture of outpatient psychotherapy, and to only see people who come in through the door and sit in the waiting rooms (although there are exceptions). The sedentary nature of child and adolescent teams may be a result of their underfunding, and long wait lists, but it might also be because of the outpatient culture that they have developed.

183 We have the same problem with most of our AOD services. Most of them do not see families and do not do home visits. One wonders why they do not support the families or try to strengthen the families to be able to more effectively help and set limits with the person who has the AOD problem in the family.

184 In NSW, the Premier's Special Commission of Inquiry into the Drug "Ice" (**Ice Commission**) recently published its report. I gave evidence to the Ice Commission, and I made recommendations as to how to make AOD teams more actively responsive, more mobile and more likely to see families or partners rather than seeing only individuals. A copy of my evidence is attached at AR-5. For the resulting report, see NSW, Ice Commission, *Special Commission of Inquiry into Crystal Methamphetamine and Other Amphetamine-type Stimulants* (2020) <www.dpc.nsw.gov.au>.

185 A person who is particularly knowledgeable on the topic of the intersection between mental health and AOD in young people is Professor Maree Teesson, AC, whose professional credentials I discussed above at paragraph 45). As I said above, she is the Director of the NHMRC Centre of Research Excellence in Prevention and Early Intervention in Mental Illness and Substance Use. The Centre conducts research on co-occurring mental illness and drug and alcohol problems, and they work particularly with school kids and young people. They have a large range of interventions that are well-researched. They address not only psychosis, depression and anxiety, but have also have done some very high-grade research on the interaction of personality disorders in people with drug and alcohol problems

Supporting individuals, communities and groups with different co-morbidities to access high quality and suitable mental health services

186 To support people with comorbidities, the key principle is to treat both disorders together. We should not try to send a person to one service first and the other service second.

187 The best way to treat both of a person's disorders together is to use an integrated team from a service hub. At one stage, we (Cleneghan P et al, 1996, 1998) applied an evidence base to having dual-disorder teams. We did not have continued funding to continue beyond our studies. We ran and trained dual-disorder teams, including ours at Royal North Shore (Sydney) Community Mental Health Services, the members of which were drawn from the other teams. We did not have any new funding to create entirely new teams, so they were de-facto teams.

188 For further information, see:

(a) Clenaghan, P.S., Rosen, A. and Colechin A (1996) Serious Mental Illness and Problematic Substance Abuse, *Journal of Substance Misuse*, 1, 199-204; and

(b) Clenaghan, P., Moore, A., Clarke, S., Rosen, A., Van Bysterveld, M., Friel, O., Spilsbury, G. (1996) Damp House, developing more effective treatment strategies for people with a serious mental illness and problematic substance use. The Mental Health Services (TheMHS) Conference Proceedings:71-78.

189 Mental health teams and AOD teams used to fight about whether a person's disorder was primarily a drug and alcohol disorder, or whether it was primarily a mental health disorder. Each one thought it was the job of the other to treat the person. The dual disorder was not so much in the clientele as it was in the *organisations*. Such dysfunctional silos persist in some regions.

190 In our study, we found that the dual-diagnosis teams worked well for treating AOD and mental illness together. The evidence showed us that if you refrain from designating one or the other as the primary disorder, and you deal with problems together, you achieve better outcomes. You need to provide the person with good services for mental health and good services for the drug and alcohol problem, and their physical consequences, working together, and stop arguing over which disorder was the begetter of the other. Our study was in relation to the comorbidity of mental health disorders with AOD disorders, but it is probably true of other co-occurring disorders too.

191 The best way to provide mental health services and AOD services together is to use a collaborative team approach within a service hub. The hub would contain people with expertise in both kinds of disorders. Integrated teams are effective, which is why ACT teams usually include a vocational specialist (somebody who can help the person get a

job), a drug and alcohol specialist (because at the level of severe and complex disorders, drug and alcohol use is a big component) and a few other specialists too. For more information on ACT teams, see Alan Rosen et al, above at paragraph 34.

192 An increasing number of professional roles are developing an evidence base that supports their inclusion in integrated teams. For example, there is an evidence base for including community pharmacists in teams on a part-time basis (see Bell S, O'Reilly C et al). Community pharmacists can talk to the service providers at their weekly case meetings, check on drug effectiveness, dosages, adverse effects and interactions, as well as talk with service user groups, and to groups of families.

193 The other people we need on the teams, on at least a part-time basis, are exercise physiologists and dieticians. The inclusion of these professionals is helpful for treating co-occurring physical disorders. If you have a mental disorder, you are also likely to have a physical disorder. That may be because you have been neglecting your physical health, or because your medications have side effects like weight gain, cardiovascular or metabolic problems (see Curtis J, Shiers D et al).

194 There are other comorbidities, the treatment of which could benefit from an integrated team approach. One of these is the comorbidity between mental health and forensic issues. Another is the comorbidity between mental health and intellectual disabilities or developmental, cognitive and learning disorders, including Autistic spectrum and ADHD.

Interdisciplinary teams

195 It is worth considering the concept of an "interdisciplinary team". Some people use the more traditional term "*multi*disciplinary team" instead, but most of the literature on the multidisciplinary team suggests that it could merely involve a group of peoples of different professions who merely pass or occasionally commune with each other in the tea room. Whereas, when I talk about an *inter*disciplinary team, I mean that there is a division of labour and the skills of people of various professions are brought to bear around each individual case in a coordinated way. The interdisciplinary nature of the team may be developed, coordinated and monitored in the daily handover or the weekly case conference.

Achieving a balance between bed-based services and community-based services

Balancing hospital beds with bed equivalents

196 There is a need for both community mental health services and hospital inpatient services.

197 I am aware that there are still habitually entrenched and influential professional lobby groups campaigning for more psychiatric beds. There are prominent groups in both Victoria, and in South Australia.

198 There have been comparisons undertaken between the evidence for bed-based mental health services and the evidence for community mental health services. Whenever the evidence is examined (on a randomised control basis), it shows either a positive result for the community alternative, or no difference between the two. There is very little evidence that says that the hospital-based alternative works best.

199 In my view, we will continue to need some inpatient beds, for urgent investigation and monitoring, on safety grounds and for the purpose of fulfilling our duty of care. For the same reasons, we also need some locked beds. We cannot do what in absolute terms the UN-CRPD is aiming for, which is to have no involuntary services.

200 The evidence base suggests that we should be shifting the centre of gravity of mental health services from hospital-centric services to community-based services. More specifically, we should be shifting away from hospital-centric services that are based in the hospital and that have token community outreach (at the convenience of staff), and moving towards community-based services that utilise judicious in-reach to hospitals when absolutely necessary.

201 It is a matter of balance, and the balance should follow where the evidence leads. If we can find community alternatives, and if they are properly researched and shown to be more cost effective than their hospital based equivalents, then we should be stabilising those community-based services.

202 Beyond rebalancing services, we should also be considering what proxies there might be for hospital beds. For example, additional acute inpatient beds could be used flexibly on the basis of whether they are needed as inpatient beds or as HITH diversion from inpatient services. For more on alternatives in inpatient beds, see above at paragraphs 20 and 28.

203 In the aftermath of COVID-19, many services will be saying, "*We need to become mainly a telehealth service, doing an occasional home visit if we absolutely have to.*" But in planning for the long-term, we need to be striking a balance between digital services on the one hand, and in-person services and assertive outreach services on the other.

Compulsory treatment

204 There is evidence that CTOs also work in the community. Some involuntary services work well, but they need to be used in a focused and explicit way (as I said above at paragraphs

169 and 170). CTOs should not be used only because care cannot otherwise be found in the community, or because case notes on people in the community are not allowed to be kept. In other words, CTOs should not be used as a proxy for ensuring that people receive care when they otherwise would not.

205 The largest evidence base for the effectiveness of CTOs comes from the Victorian Psychiatric Case Register (Segal S et al c/o Dr Ruth Vine). I believe that this is the largest study in the world on the effectiveness of compulsory treatment.

206 But there is a balance to be struck. There is also literature that suggests that we should be trying to encourage people to work on a voluntary basis as well, and be using compulsory treatment sparingly.

207 For more on the use of compulsory treatment, see:

(a) Rosen, Rosen and McGorry, above at paragraph 108(a); and

(b) Mezzina et al, above at paragraph 108(b).

Service supply, offering and mix

National Mental Health Service Planning Framework and complementary tools

208 The National Mental Health Service Planning Framework (**NMHSPF**) is not an internationally standardized comparative resource. It is not aligned squarely with evidence based interventions and service delivery systems, and has many problems to overcome for achieving and sustaining optimal standards of care. I draw on a comparative analysis of methods, by Daniel Rock, WA Mental Health Commission, which is not yet published.

209 The NMHSPF is not transparent but still an opaque secret work in progress, not openly available for the mental health community to scrutinize, respond to, or suggest amendments to, during its prolonged development. It has been kept under wraps by Australian Governments for many years, ostensibly because of its cost implications, which means the authors are obliged to keep endeavouring to update it in camera. The NMHSPF badly needs to see the light of day. This need is discussed in Roger Gurr et al, *TAMHSS Submission to the Productivity Commission*, above at paragraph 81.

210 Second, the NMHSPF does not map squarely onto any international standard tools for international comparison of trends. There are international standard planning tools which define what a good quality and best-practice service is, and how much resources each service may need, which therefore invites international comparisons.

211 One complementary candidate tool for Australian conditions also under further development, and which could be aligned with the NMHPF if need be, is the Essential Components of Care Framework (**ECC Framework**), which maps directly onto the evidence base for each stage of life and each type of disorder. The ECC Framework has a menu and a framework for choosing evidence-based interventions and delivery systems. It provides interventions that you can have confidence in, because they are mostly squarely internationally evidence-based, and not just based on an evidence-informed adaptation. (See Gurr R, Rosen A et al, Response to Productivity Commission Draft Report on Mental Health Services: TAMHSS Essential Components of Care).

Governance

Distribution of governance and commissioning of mental health services across multiple entities

Development of Mental Health Commissions in Australia

212 I have been involved in the development of mental health commissions, and with others I have contributed to the literature on this topic at the time when the mental health commissions were starting.

213 Victoria has a most proactive and committed complaints commission, but could really do with a separate reform-oriented statutory mental health commission, reporting independently to the state parliament. As demonstrated in New Zealand, if the mental health commission is brought under a complaints commission, the priorities, functions and sheer volume and associated workload of the latter soon dominate and eclipse those of the former.

214 A Mental Health Commission could well have a complementary role to a Mental Health Complaints Commission. Whereas having to respond to individual complaints could distract from the reform-driving focus of a mental health commission, the mental health commission should always respond promptly to de-identified clusters and trends complaints reported by a mental health complaints commission.

215 We at The Mental Health Services (**TheMHS**) Conference of Australia & New Zealand, among others in the Australian mental health community, advocated strongly for mental health commissions on the basis of the positive impact and experience of the original New Zealand Mental Health and Wellbeing Commission. We also then worked closely with the Mental Health Commission of Canada, who have also presented at our bi-national conferences.

216 When there was just the New Zealand Commission, and before the Mental Health Commission of Canada had been established, Dermot Casey, the then most senior official for Mental Health in the Australian Government stated that a national mental health commission might work in New Zealand as a one-state nation, was most unlikely to work in an Australian federated context with such diverse state health and mental health systems.

217 However, when the Mental Health Commission of Canada was established, it showed that a national commission could work in a federal system. The Mental Health Commission of Canada has, in my view, done well in terms of policy development, and its research has led the way in addressing issues like homelessness and supported housing. It has undertaken many other encouraging initiatives, such as providing a knowledge base for the whole community on mental health, and providing a knowledge exchange system.

218 The first mental health commission in Australia was in Western Australia. Many advocates for a commission were surprised, as we at TheMHS thought we had been proposing a national commission. Then Prime Minister Julia Gillard and then Mental Health Minister Mark Butler acquiesced to clamour from all quarters of the Mental Health community for a National Mental Health Commission and at the same time other state commissions started to develop. In a sense, Australia has embarked on an innovative experiment, because, as far as I know, we are the only country that has both a national commission and a series of state commissions. There is also the Victorian Mental Health Complaints Commissioner, and the Office of Mental Health in the Australian Capital Territory, which network with the other commissions and the New Zealand commission. It makes their combined work complex, but it also makes it rich in terms of the diversity of these agencies, and the regular networking and the division of labour that are possible. Sebastian Rosenberg (see references at 75(b), 228 and 229(c)) and TheMHS conference, through their annual Mental Health Commission symposium, have continued to be active in keeping a watching brief on the effectiveness of the Australian and New Zealand Mental Health Commissions.

219 I believe that Australia's various mental health commissions usually meet together quarterly. In my experience, there have, in the past, been informal divisions of labour between the various commissions. Different commissions would take on different tasks on behalf of the whole. The entities currently responsible need to find a similar way of working collaboratively. This is co-design on the macro level.

Finding a balance between independence from and co-operation with government

220 Before the various commissions were established, the Australian mental health community was seeking commissions that, while not fully independent of government,

would be at arm's length of government. They wanted commissions that would be prepared both to give strong advice to governments and to work respectfully with them—in other words, to walk together with them and say, "We'll solve this together, with respect."

221 When Mark Butler was Federal Minister for Mental Health and Ageing (which office he occupied from September 2010 to June 2013), the National Mental Health Commission was established, and sat within the Department of Prime Minister and Cabinet (**DPMC**). It has since been taken out of DPMC, but I think it is becoming increasingly involved with DPMC again, mainly through its current CEO, Christine Morgan.

222 The mental health commissions need to come back to the principles of why we have such commissions, and why many consumers and families in the mental health community had grounds for wanting those commissions. Mental health commissions should not be seen as merely a voice of government. I am sure that they do not conceive of themselves that way, but I think that sometimes governments would like them to work that way, as entities that do tasks for government and that represent the government view.

223 Relationships between the commissions and governments were not supposed to be combative. Those relationships were supposed to be co-operative, but with the commission acting as an independent voice for reform, at arm's length from government. The commissions should be in close communication with all the stakeholder groups (including services-users, their families and providers), and should also be able to represent and amplify the voices of those stakeholders to government. (See Rosen A, 2012, Rosenberg & Rosen, 2012).

224 I was one of the inaugural Deputy Commissioners of the Mental Health Commission of NSW (**MHC NSW**). At times, the relationships between our National and State Mental Health Commissions and their respective governments have worked. But at other times, the relationship has been too close, and the government or their ministries have expected the Mental Health Commission to toe the line and to do the government's bidding, or have made it difficult for the Mental Health Commission if it did not. On the other hand, I think some Mental Health Commissions have sometimes allowed themselves to get too close to governments, or to become acquiescent or mouthpieces for them, when they should have been much more independent.

225 These commissions are still young, there is much to learn in their development, in Australia and elsewhere, and I am hopeful that well-differentiated and effective complementary roles will be established, respected and sustained over time.

226 It is important that a mental health commission be a prominent, well-known voice for better mental health and wellbeing services in the community, and that it provide a regular

conduit between stakeholder groups and government. It is also important for it strongly to represent the stakeholder interests, as a voice to government, and also to report back to those stakeholder groups. It is a difficult balance.

Examples of commissions that have good relationships with government

227 I do not think that any jurisdiction strikes the balance between independence and co-operation perfectly, but there have been some very strong examples of how to run an independent commission that is also highly respected by governments of all persuasions. The examples I give in particular are the mental health commissions of New Zealand and Canada.

228 Australian Mental Health Commissions should be resourced to and mandated to take up much more energetically their key roles in the rigorous monitoring multiple forms of accountability for their jurisdictional mental health services. See Rosenberg S P, Hickie I B, McGorry P D, Salvador-Carulla L, Burns J, Christensen H, Mendoza J, Rosen A, Russell L M, and Sinclair S, Using accountability for mental health to drive reform (2015) 203(8) *The Medical Journal of Australia* 328.

229 For more information on the operation of mental health commissions, see:

(a) Alan Rosen, "Mental Health Commissions of Different Flavours: Can They Be Effective Vehicles for Mental Health Service System Reform? Provisional Typologies and Trajectories" (2012) 17 *Mental Health Review Journal* 167;

(b) Rosenberg S and Rosen A, "It's Raining Mental Health Commissions", above at paragraph 75(b);

(c) Sebastian Rosenberg and Alan Rosen, "Can Mental Health Commissions Really Drive Reform? Towards Better Resourcing, Services, Accountability and Stakeholder Engagement" (2012) 20 *Australasian Psychiatry* 193;

(d) van Schoubroeck, L On the WA Mental Health Commission, above at paragraph 75(a); and

(e) Roger Gurr et al, *TAMHSS Submission to the Productivity Commission*, above at paragraph 81, 17–19.

Challenges of a system where responsibility for governance and commissioning is distributed across multiple entities

230 Responsibility for the governance and commissioning of mental health services in Australia is distributed across multiple entities. The distribution of governance and commissioning is almost unavoidable in Australia, because of the nature of our governmental system. The distribution presents us with two challenges. The first

challenge is to achieve teamwork at the micro level. The second challenge is to bring together the different providers and stakeholder groups at the macro level.

231 First, we need to achieve integrated interdisciplinary team-work at a micro level, with a well-coordinated division of labour around the unique needs of individual service-users and their families, and a careful balance between in-person, including home outreach services, and digital substitution and augmentation.

232 The second issue is about how we bring together different stakeholder groups and service providers at the macro level. There are the public mental health services, NGOs, fee-for-service private but publically subsidised providers, federal and state funders, and the NDIS. To bring all those together, as a healthcare ecosystem (Rosen A et al 2020), there needs to be collaborative co-design between all stakeholders, a unitary strategic mental health plan and a pooling of funds at the regional level, with regional commissioning. For more on regional commissioning, see:

(a) Roger Gurr et al, *TAMHSS Submission to the Productivity Commission*, above at paragraph 81, 18–19; and

(b) Australian Healthcare and Hospitals Association, TheMHS Conference Inc and PricewaterhouseCoopers, 'Mental Health Funding Methodologies' (Roundtable Discussion Paper, September 2008) 15–27.

233 We are achieving some degree of co-design on the micro level. When service providers and stakeholder groups work together on co-design, it brings an experience of potency. That feeling is important for our service-user and family groups, because although they might feel unable to make much headway in their own lives, they feel they can contribute to improving services. Experiencing such a sense of choice, control and potency, of being able to improve the service for the benefit of others is also therapeutic and instils hope in both the providers and service-users. The way to cope with change that is slow is to collaborate and push forward together. I think we collaborate well at the micro level, and we should be doing it at the macro level too.

Benefits and limitations of integrating the governance arrangements of mental health services and broader health services at a system level

234 In integrating the governance arrangements of mental health services and broader health services, we need to achieve a delicate balance. Some people still want the governance of mental health services to be quite separate from the governance of broader health services, particularly as so many general healthcare systems habitually expropriate or divert mental health budgets and expenditure for other priorities. Some senior mental health directors are nostalgic for how things were in the old days, when all or most mental

health care was all run through the psychiatric hospitals, and in some states it was run as one discrete organisation. In WA, the Mental Health Commission has control of the mental health budget, and disperses it on a tight contractual basis, but also works closely with then general health components of the hospital and health system.

235 There are benefits to having mental health services close to broader health services. One benefit is that it means people receiving any kind of healthcare can access mental health services. However, all aspects of health need mental health services. For example, I have heard anecdotes from several jurisdictions that the coronavirus pandemic has caused some hospital staff to become so distressed that they are now approaching their mental health colleagues in the hospital and asking for help. They need someone to talk them through it: "*How am I going to handle it? How can we handle our anxiety, our grief, at seeing young people get very ill or die?*"

236 The role of providing comfort and hope is an appropriate one for mental health to perform, because mental health does have a wider psychosocial cultural view. It is also good for mental health to convey its wider view to other departments, and to humanise its operations more. That sort of role needs to be recognised more widely within organisations.

237 However, the mental health system is already poorly funded and is not funded to perform that role. The demands on it are increasing, and it is also expected to provide that sort of comfort and hope to staff in the rest of the hospital.

Forensic mental health

Key features of a successful interface between community-based mental health programs and the criminal justice system

238 The interface between the community mental health system and the criminal justice system is another sub-set of co-occurring disorders. Again, we need people in the workforce who are seasoned with handling issues of probation and parole. We also need people who are familiar with issues around mental health, AOD, violence and how to work with perpetrators.

239 This comes back to the experience, training and expertise that exist within teams, and to the importance of selecting teams well.

240 It is important that we have continuity of both the drug and alcohol courts and mental health courts. In other words, we need to retain other ways of working with people beyond a black and white judicial system. One would hope that there are judicial officers in those

courts who have a special vocation for working with psychiatrically & AOD disabled populations.

Workforce

Fostering a workforce that has the values and skills to provide consumer-focused, recovery-oriented and safe services in a collaborative way

241 As I have said, there are some issues that everybody in a community-based mental health system should be trained in, such as domestic violence, and cultural and linguistic differences: see above at paragraph 128. I have seen this training implemented well.

242 I always thought that if we worked on mental health reform, and if we relied on good quality research in doing that, then reforms would keep growing incrementally. However, over a long career, I have discovered that mental health reform is more like a rollercoaster. Sometimes that is because different lobby groups get the ear of different administrations that come and go, and then the new administrations change the system and the work culture and the stability is lost. This can occur as different political and ideological persuasions alternate, and want to make their mark.

243 We need build the components of our mental health system, including the workforce, for the long-term stability of the system. We do not want so much inflexible stability that the system stops developing; we need an interplay between stability and change. This interplay is like evolutionary genetics: you conserve what still works well, and you change what is not. The same principle applies for the workforce. We do not want a staid workforce; we want one that really responds to the principle of lifelong learning and learning through the lifespan.

244 The application of that principle is encouraging to most people. But some people do not want to change, and may also feel devalued for the best of what they do. We need to ensure that people are valued for what is worth conserving; the trade-off is them being prepared to accept help with constructive change. Sometimes these people are very accurate and useful critics of the newest evidence-free fad that has just come in.

245 That is why we suggested that there should be an Australian Nationally networked Institute for the Mental Health workforce: see above at paragraphs 9 to 15. The National Institute would include training for drug and alcohol and other co-occurring disorders. It would be inclusive, providing training not only to the professionals but also to the peer workers, whether they are service-users or their families. The National Institute would need to have a base in every state, and Victoria has a good chance of being the kick-starter of it, because in Victoria principles similar to a National Institute have been

recommended as a high level priority (see, for example, Recommendation 1 of the Interim Report).

246 I agree with the RANZCP submission to RCVMHS which recommends that junior and senior (year 1 and 2) medical residents should be encouraged and able to do rotational placements in psychiatric services. Most generalists will be required to do a substantial proportion of mental health work as part of their medical careers, and it will interest some in doing psychiatry specialty training. The too few available residency rotational positions made available to psychiatry so far, though very slowly improving in particular LHN's, is a form of health service structural discrimination. These residencies should not only be offered in inpatient units but in community and consultation-liaison mental health teams. Moreover, most medical schools, with their very crowded curricula, still fail to provide enough time for training and experiential placements in psychiatry for their medical students, as psychiatry is still regarded as low in the medical professional pecking order. This too must be corrected.

Key features of exemplary workforce strategies or initiatives

247 Teams require opportunities for refresher training, and they develop through communities of practice. Providing these trainings, supervision and pastoral mentoring networks to sustain the workforce and facilitating "communities of practice" to further encourage learning between teams and best practices, could be part of the work of a State or National Institute.

Refresher training opportunities for teams

248 In NSW and Victoria, among other places, when the evidence-based teams (such as the crisis teams and the ACT teams) started working, they had extensive training programs. When teams were initially employed, they might have spent the first six to twelve weeks offline, while they received intensive training as a whole team. However, this intensive team training only occurred at the start, during the orientation period. After a team was initially trained, and put into action, it was deemed too hard to take the team offline ever again.

249 When subsequent turnover of staff occurred, there were no such training opportunities. People would undertake an individual course, but they were doing it alone and not with their colleagues. The lack of everyone in a team undertaking training together made a big difference in terms of blending a culture. One criterion of a successful program is the capacity to take teams offline periodically and providing them with sufficient clinical cover to conduct refresher training workshops, in addition to providing them with a sound initial orientation and training period.

Communities of practice

250 When our first psychiatric crisis and ACT teams in Northern Sydney realised in the mid-80's that they were not necessarily going to have another training period, nor the time to meet the almost continual demand to do "show and tell" training for new teams, they developed "forums" with their colleagues across Australia. There was a forum for crisis work, a forum for ACT, one for living skills centres, one for residential services. Those forums are what we these days call communities of practice.

251 In organisational fields, there is literature on the concept of communities of practice. In a community of practice, you are supposed to undertake a similar type of program, and there are guidelines, evidence-based fidelity criteria or Policy Implementation Guides (**PIGS**), as they were called in Britain. In other words, communities of practice draw on manualised sets of guidelines about how to conduct teams in an evidence-based way, and then swap notes for hints about how best to interpret and carry out these guidelines most effectively.

252 Communities of practice emerged to sort out critical incidents and problems that people could not solve. They emerged so that people could help each other with those problems and could identify the learning and growing points from each-others' teams.

Examples of excellent workforce strategies and initiatives

253 An example of a good workforce initiative was the communities of practice that developed around Australia. The development of communities of practice was also part of the early development of The Mental Health Services (**TheMHS**) Conference of Australia and New Zealand. The TheMHS Conference is a partnership of all mental health service stakeholders, including service-users, primary and secondary care providers, families, indigenous and transcultural communities, management, government, and media. It is centrally about *services* and people doing therapeutic work in teams and the evidence behind them. For the last 30 years, TheMHS has convened in different cities of Australia & New Zealand and also conducts the Australian & New Zealand Mental Health Service Achievement Awards annually on behalf of both national governments on this basis.

254 In our various regions, we need to have refresher courses as well as good training programs. One of the models Australia has contributed worldwide has been Orygen, and its early intervention in psychosis guidelines and training. Orygen is applying similar building blocks of service or components that evolved from our research and practices in Northern & Western Sydney. For example, Orygen has an Early Psychosis Prevention and Intervention Centre (**EPPIC**) that works with young people with psychotic disorders. Within the EPPIC, there is the crisis team and the ACT team. Orygen took many of the elements for which there was a strong evidence base, and put them together in a youth-

friendly way. Orygen also developed more service components around personality disorder programs, employment programs, and physical care programs.

255 To support the creation of a new team from existing resources in a regional mental health service, it is not enough to attend to that new team's training. It is important to orient the whole mental health service from which each member of the EIP team is drawn, to the effectiveness and utility of an EIP team, which can be done by giving all teams some elementary training about the purpose of the new team. That is how we started three early intervention in psychosis teams out of existing mental health service resources in northern Sydney. We gave people, on an area-wide basis, training in early intervention. This was important as it meant the team would see the function of it. They would see that by donating a staff member here and there to the creation of a new early intervention team, some of the burden would be removed from other teams who may have otherwise found it very time consuming to work with, for example, a young person in an acute episode of psychosis. Because we took this approach, it was all done very co-operatively and appreciatively.

256 Another strategy for creating a new team is to bring in service-users and families from that aspect of service. For example, if you are training people to be part of an early intervention team, then you should bring in people who have had some experience of first episode psychosis as individuals and as families. You apply the same principle if you are training a crisis team: you bring in some consumers and families who have had their own crises, either well-handled or maybe not so well handled. The consumers and families can give feedback and speak from that stakeholder view. The principle is co-creation: co-creation of knowledge, skills and wisdom, to develop congenial service delivery sub-systems.

Next steps for helping the workforce to acquire the values and skills needed to provide consumer-focused, recovery-oriented and safe services in a collaborative, accountable and transparent way

Establishing a knowledge exchange centre

257 To help the workforce to acquire the skills they will need to provide consumer-focused, recovery-oriented care we need to establish a National Institute like the one I discussed above at paragraphs 9 to 15.

258 The first thing that the National Institute should do is set up a knowledge exchange centre. There are already translational research centres, where the research on the best evidence-based methods is translated into language that is useable for providers, service users, families and mental health communities. The knowledge exchange centre would

give these various stakeholders summaries of the latest evidence on the best ways to work, and guidelines for applying that knowledge.

259 In establishing the knowledge exchange centre, we might also follow the example of the Mental Health Commission of Canada, which started with a national knowledge exchange centre.

Establishing pastoral mentorship programs and communities of practice

260 The National Institute would not be limited to teaching new skills. It would also have a role in ensuring that there are pastoral mentorship programs and communities of practice, which reassure people that they do not have to work these things out alone. They can stop people from absorbing too much stress and trauma, and support people to keep buoyant within the system.

261 In Australia, we have recently been through an era of multiple disasters including drought, bush fires and coronavirus. In this era, the knowledge exchange centre would be particularly relevant. That is because the first stage of a National Institute would not just provide training but also supervision systems, pastoral mentorship systems, and communities of practice. The goal would be to support the workforce not just at the level of knowledge and skills, but also at the level of feelings and coping.

262 It is a matter of making sure that staff are supported through tough times. To some extent, workers in the field of mental health will always be dealing with stress and trauma. Unless there is support in the system, it is very easy to start suffering vicarious trauma as a workforce. Vicarious trauma amounts to absorbing the expression of the experience of trauma that you witness in your clientele.

263 Mental health workers need to know strategies for dealing with the risk of vicarious trauma. Many of the strategies are interpersonal. For example, counselling or communities of practice, where a worker can swap experiences with their colleagues from other services. I discuss communities of practice in more detail above at paragraphs 250 to 252.

Leadership, partnership and change

Supporting leadership in the mental health sector to support the delivery of reform

264 There are two things that we can do to support leadership in the mental health sector: first, ensure that leadership rests in functional and supportive teams, not in solitary individuals; and secondly, create a plan that connects all services within a particular catchment area.

265 First, it is important that leadership comes in the form of a leadership group that is both functional and supportive. A demagogic leader wants to work alone by charisma, fame or renown. Charisma might help you get an organisation going, but it is not an advantage for sustaining a service in the long term. To be a functional leader, you need a leadership team which supports you in your leadership role. You and your leadership team need to be able to delegate and share the work around.

266 There was a famous professor of psychiatry and psychotherapy at University of Wisconsin, USA called Carl Whitaker, who said that every mental health professional (including those in leadership positions) needs a "cuddle group". This is a group of fellow professionals with whom you can debrief at the end of a day, so they can leave work issues at work, and not feel the need to blow off steam about work issues at home with their families. This is one benefit to having a functional and supportive leadership group.

267 Secondly, there needs to be one strategic plan, not just for clinical services but also for all the services that work in a particular catchment area. That provides another set of relationships, and those relationships should also be mutually supportive and enriching. This should happen at different levels so that you should then go from the service to a regional commissioning authority (which pools the funding and commissions the best evidence-based interventions and service delivery systems). It is like a set of Russian dolls: you work first of all at the level of the person, along with their family, case manager and clinicians; then you work at the level of the team; then at the level of the service; the level of the catchment; the level of the community; the region; the whole state, and then the nation.

268 In each of these levels, we need not only a supportive environment, but also a functional division of labour. We should model it at every level, whether for a therapeutic encounter or developing a unitary strategic plan for a region. It should begin from the grass roots service-user and family level, to the team, to the service, to the regional or state level of policy making and funding. We need an emphasis of "bottom-up" consultation, substantial consensus and development informing responsive "top-down" decision-making.

Steps governments can take to support workforces through periods of significant change

269 In its Interim Report, the Royal Commission made a recommendation about a Victorian Collaborative Centre (Recommendation 1), and another about providing a "mental health leadership network" (Recommendation 7). Governments could support workforces through periods of significant change by combining those two recommendations into one, and pushing that initiative forward. They should do so along with the principles I have discussed of working in a supportive group and knowing when and how to ask for help,

on the basis of the principle and role modelling, at every level of the organisation, that knowing how and when to ask for help should be considered to be an important skill, not a failure.

270 Governments in every jurisdiction, not just Victoria, should create an equivalent of what the Royal Commission has recommended for Victoria, the Victorian Collaborative Centre. The existence of such an entity in each jurisdiction would plant the seed of a more national network.

Physical infrastructure

Design principles for mental health facilities

Physical features

271 There is a literature available on the key principles of design for mental health facilities. The literature comes mainly from architects and designers who are interested in this field such as Environmental Design Research Association, USA (EDRA), Penny Coombes, Queensland, Mungo Smith, Sydney, Australia, and sometimes from design consultants. The literature specifies things like:

(a) do not build internal offices;

(b) create offices that have windows;

(c) make sure some greenery or some blue sky is visible from indoors;

(d) make sure that there are some built-in, common spaces that are roomy; and

(e) make sure people are not cooped up in tiny cubicles, or in high dependency units with miniscule spaces, inside and out.

272 Some of these elements go towards the aesthetics of facilities, and others go towards security and safety. On the aesthetic side of things, we know that people lift in mood if they can see the sky through the windows, and drop in mood if they are put in a windowless office and left there while a therapist is running late or having a cup of tea between patients.

273 On the safety side of things, for a person working in a community mental health centre or an inpatient unit, they should be having an interview in an office that has two doors: one door through which the person enters the room, and the other door for the worker to get out through if the person becomes erratic.

274 Another issue around the design of facilities is that people need space, both indoors and outdoors. The evidence shows that the more space an institution allows per person, the easier it is to manage people who are on the edge of re-kindling violence. The more you

coop people up in small courtyards or in confinement, seclusion or restraint, the more you will breed violence. Confining people to small spaces works against the interests of the service.

Respite centres and places of "asylum"

275 Environments like residential units should be more informal, homely and welcoming. There is an evidence base from the UK where researchers have compared inpatient units with community-based 24 hour supervised residential respite centres. Respite centres are usually out in the community, near shopping centres and transport routes. There are usually no locked doors; people can come and go. There is, however, usually 24-hour support available.

276 People who are in distress or who are feeling on the edge of suicide often feel much more comfortable going to respite centres than to places where they are likely to be locked up and possibly secluded. There are many people who will do anything to stay out of an inpatient unit, but who will willingly approach a respite centre. They will come in under their own steam if they are allowed to, because they feel that there will be people there who understand them, and see it as a place of refuge. The UK studies have shown that people with similar levels of psychopathology and risk find respite centres more acceptable environments to receive treatment in, and the clinical outcomes are at least as good (see for example Sonia Johnson et al (2010) Where next with residential alternatives to admission? 197(S53) *British Journal of Psychiatry* S52-S54; Brynmor Lloyd-Evans, Sonia Johnson, Nicola Morant (2010) Alternatives to standard acute in-patient care in England: Differences in content of care and staff-patient contact, 197(S53) *British Journal of Psychiatry* S46-S51).

277 Some people do need a place of asylum — asylum in the best sense, not in the old sense of psychiatric hospital asylums.

278 The best definition of "asylum" that I know of is from John Wing, former Professor of the Institute of Psychiatry, Psychology and Neuroscience, a school of King's College London (formerly the Institute of Psychiatry). He said that asylum is two things. It is a haven in which to take refuge, and it is a harbour from which to set out again. The haven is the refuge part, where a person feels that it is a place of safety, a place where they will be looked after, a place of peace and serenity.

279 The second part of the definition is often left out, though it is just as important:, the idea of having a harbour from which to set out again. If you are in moored in a harbour, you need to prepare your boat before you can set sail, and you may need help with that. The challenge for us is to develop that sense of asylum in the community.

Impact of COVID-19 pandemic

280 As I have said above, a recommendation that is open for the Royal Commission to make is that all the additional beds recommended in the Interim Report should be resourced and applied flexibly on the basis of whether they are needed as inpatient beds or as HITH diversion from inpatient services: see above at paragraphs 36 to 39.

281 My colleagues and I from different health and mental health organisations have been consulting with both federal and state governments about the mental health response to COVID-19. Over the weeks, we were aware that there might be a rush on general hospital services. That has not come to pass, because of government initiatives, including tracing and testing, and the community's co-operation with spatial distancing, separation and isolation rules.

282 We have missed one bullet, and the next bullet we will need to deal with may well be the aftermath. In a disaster of any magnitude, there is usually a delayed response with severe and complex mental illness. There may be a delayed surge, usually within several of months of the main disaster.

Possible surges in demand in the wake of the pandemic: can we "flatten the curve" of demand for mental health services?

283 While the COVID-19 disaster was unfolding, many people postponed their clinical needs and tried to avoid hospital and services. Some may have become very isolated, or disorganised with their medication, or might have avoided or run out of their medication. Many have delayed going to their GP or outpatient appointments. People are not coming in for hospital admission. Hospitals were expecting their admission units to be inundated, but many admission units have been under-utilised, with fewer presentations than usual.

284 There may be three possible types of delayed surges in demand for mental health services in the aftermath of COVID-19. The surges will not necessarily occur together, because they will each follow their own trajectory. One surge may be made up of people with severe, persistent and complex mental illnesses and who have become isolated or unsupported. Some of those people will go off medication, and their physical health is likely to be affected. Some of them are just not getting their injections that they need, and some of them have other disorders alongside their mental disorder (for example, cardiovascular disease, diabetes) which are not being looked after either.

285 A second surge may be made up of people who are predisposed to, and who have during the pandemic developed, an initial episode or exacerbation of clinically significant depression, anxiety or suicidality, especially associated with isolation and loneliness, fear of loss of income, purposeful activity, and employment.

286 A third possible surge may be made up of people who are grieving losses that they sustained during and because of the pandemic. They may be experiencing grief over the loss of relationships caused by, for example, the deaths of loved ones or the loss of contact between grandparents and grandchildren. This group of people is also made up of people who are experiencing severe financial stress or grief over the loss of jobs and the loss of businesses, or the loss of purpose and/or identity which was wrapped up in their work or business. This wave of demand on the mental health system is yet to happen, but if and when it does happen, it will hit hard and last for many months or years.

287 We need to prepare for these possible surges. It is common now to speak of "flattening the curve" in relation to the number of cases of COVID-19; I think we need to talk about flattening the curve of demand for mental health services. We need to flatten the mental health curve for two reasons: first, because we do not want the surges to overwhelm the system; and secondly, because if people with certain disorders are having to present suddenly in hospital, then that is a sign that we are leaving the treatment of those disorders too late, when they are by now life-threatening, whereas we could have intervened much earlier.

288 In April 2020, three co-authors (Rosen A, McGorry P, Herrman H) put together a document called "Call for a Comprehensive National Mental Health Plan to Respond to the Novel Coronavirus (COVID-19) Pandemic" (**Call to Action**) with 38 co-signatories, including the presidents & CEO's of RANZCP, of the AMA and several other major mental health organisations.

289 The Call to Action takes the form of a memorandum, which is addressed to the Commonwealth Minister for Health, the Shadow Minister for Health, the Principal Medical Advisor of the Commonwealth Department of Health, and the CEO and Chair of the National Mental Health Commission. The Call to Action urges Australian governments to implement a comprehensive National Mental Health Plan to respond to the COVID-19 pandemic. It seeks to balance digital services with adequate continuing capacity and activity to provide in-person and mobile home-based community mental health services, wherever and whenever needed. It has been signed by dozens of senior medical and mental health professionals and academics. Attached to this statement and marked "AR-6" is a copy of the Call to Action.

290 The Commonwealth Mental Health Plan released on 15 May 2020 in response to the COVID-19 Pandemic clearly acknowledges these needs. Disappointingly, however, there is still so far a complete lack of commitment and action from the Commonwealth to ensure upgrading of familiar, in-person, local and regional mental health services, with assertive outreach capacity in balance with temporary enhancements in telehealth services.

291 We need the federal Government to work with the states and territories to enhance our depleted community mental health services. Along with neglect of those with the highest existing needs, the media promotion and online services will escalate, refer and unlock demand that local mental health services and GPs will not be able to meet. Of course, states and territories have to pull their weight more and do their share too. But so far, the Commonwealth has reneged on its pivotal role in both orchestrating and helping them to resource a coherent and consistent national humane response to save the lives of people struggling with mental illnesses and trauma in the wake of COVID-19, just as the Commonwealth did for the acute physical health needs arising from this pandemic.

sign here ►

print name Alan Rosen

date 23 July 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AR-1

This is the attachment marked "AR-1" referred to in the witness statement of Alan Rosen dated 23 July 2020.

Alan Rosen, AO, Brief CV.

Born Perth, Western Australia,
dob. 3 Jan 1946.
Married, 2 children, 3 grandchildren.
Alan.rosen@sydney.edu.au

Qualifications

MB.BS, 1971, MRCPsych,1978, DPM, 1978, MRANZCP,1981, FRANZCP, 1983, Grad Dip PAS.1985.

Positions

Senior Consultant Psychiatrist,
Professorial Fellow, Illawarra Institute of Mental Health, Faculty of Health & Behavioural Sciences, University of Wollongong;
Clinical Associate Professor, Brain & Mind Centre, University of Sydney, Australia;
Formerly Inaugural Deputy Commissioner, Mental Health Commission of New South Wales 2013-2015.
Research Psychiatrist, Centre for Rural & Remote Mental Health Services, University of Newcastle; 2008-2012
Visiting Senior Consultant Psychiatrist, Far West LHD Mental Health Service, NSW, serving indigenous and wider communities of Broken Hill, Wilcannia etc.1985-2020,
Former Service Director, and Director of Clinical Services, Royal North Shore Hospital & Community Mental Health Services, Sydney (retired 2009 after nearly 30 years of service).
Visiting Professor, University of Wisconsin, Madison,1990,
Visiting Senior Fellow, Medical Anthropology & Social Medicine, Harvard University, 2007,

Co-Convenor (with Dr Nick O'Connor) Management & Leadership seminar series, RANZCP NSW Branch, 2012-2018.
Serving on RANZCP Aboriginal & Torres Strait Islander Committee, 2016-present, & previously, RANZCP, Quality Improvement Committee,
Chair, Transforming Australia's Mental Health Service System (TAMHSS) National Network, 2019-, Deputy Chair 2012-2018.
Foundation Board-member to present, The Mental Health Service (TheMHS) Conference & Learning Network of Australia & New Zealand,
Member , Independent Health Pricing Authority, Mental Health Working Group & Consultant, 2013-
Member, Lifeline Research Foundation & Sane Australia, Clinical Advisory Group.

International advisory boards, University of California, Berkeley, WHO Collaborating Centre, Trieste Mental Health Services.
Executive Committees, World Psychiatric Association, Section of Public Policy in Psychiatry, & Section of Conflict Resolution.

Awards/Honours

Hale School Scholarship, Perth WA, 1958.
Scholarship to Perth Modern School, Perth WA, 1959.
University of Western Australia Sobotka Scholarship to read Human Sciences, Oxford University, 1972-1975,
Ian Simpson Award, Royal Australian & New Zealand College of Psychiatrists, 1994;
Margery Johnston Award, Association of Relatives and Friends of the Mentally Ill, 1989,
Officer of the Order of Australia, Queen's Birthday Honours, 2014.

Interstate and International Projects.

Reviewed mental health services for governments and administrations in 5 Australian states and the ACT, and in New Zealand.

Invited/Plenary speaker and/or performed consultancies on service development in several Australian states and territories, UK, Ireland, Norway, Netherlands, Sweden, Denmark, Italy, Germany, Switzerland, USA, Canada, China, Thailand, Hong Kong, Argentina, Spain, Portugal and New Zealand.

Presidential Invited Speaker at American Psychiatric Association annual meeting, San Francisco, May 2019, and Invited Speaker in Presidential Symposia at World Psychiatric Association world congresses, Berlin 2017 and Lisbon 2019.

Initiated and convened (with Prof Derrick Silove) the 1st continuous Australian duty psychiatrist roster in East Timor, 1999-2001.

Research and Publications.

Author or co-author of more than 150 published journal articles or chapters on research studies of 24 hour community based alternatives

to acute and long term inpatient care, rehabilitation and recovery, assertive case management and integrated mental health service systems; more inclusive interdisciplinary mental health teams, including peer workers, early intervention in psychosis; psychiatric stigma; dual disorders, deinstitutionalization, consumer issues, family interventions, Aboriginal, developing country, rural and remote mental health, cultural influences on mental health service systems, qualitative and quantitative outcome measures, (including being principal author of Life Skills Profile-a functional measure in international translations), recovery measurement, impaired practitioners, research and evaluation in mental health, service standards, the National Mental Health Strategy, global community psychiatry, Human Rights of individuals with severe and persistent mental illnesses, international comparisons between Mental Health Commissions, the History of Australian Psychiatry, the Future of Community Mental Health Services, and Climate Change Psychiatry. He is the co-editor with Peter Byrne of a current textbook: "Early Intervention in Psychiatry: EI of Nearly Everything", Wiley Blackwell, UK, 2014, and several published and unpublished reports.

Psychiatric Journal assessor, Journal Advisory Board and Doctorate co-supervisor, University of Sydney & UNSW.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AR-2

This is the attachment marked "AR-2" referred to in the witness statement of Alan Rosen dated 23 July 2020.

Australian National Institute of Mental Health

-A Nationally Consistent Evidence-Based Workforce Capacity-Building Strategy for all Mental Health Service Providers July 2020

From: *Professor Maree Teesson, AC, & Professor Alan Rosen, AO.*

The need

Effective early intervention and timely evidence-based treatment and support can significantly reduce disease burden by halting, delaying, and interrupting the onset and progression of disorders. Yet there is poor coordination and significant gaps in ensuring the capacity of our workforce to deliver cutting edge treatment and responses.

The solution

Development & Provision of a Federally funded multi-site Australian **National Institute of Mental Health** encompassing:

a) ***Workforce Resource Centre*** to provide training materials, skills enhancement courses, and a continuing supervision and mentorship system for all mental health and substance use disorders for first responders, support workers, primary care professionals, transcultural, indigenous and mental health workers for all age groups.

b) ***National Mental Health Implementation & Evaluation Unit.***

Key priorities for both are workforce capacity building and skills training, implementation, quality of service monitoring and implementation evaluation and research, in evidence-based interventions and service delivery systems for all mental health conditions and age groups.

Goal: The Australian Institute of Mental Health will be a world-first, providing an integrated platform to develop innovative responses across disciplines and disorders to build national and international multi-sectorial workforce capacity. Our vision is that world-class, innovative, evidence-based early intervention and effective treatments and care for mental health and substance use disorders will be available to all Australians. It will encompass:

Workforce Resource Hub to provide training, practice and leadership skills enhancement for all mental disorders and substance use disorders for first responders, support workers, primary care professionals, graduate mental health and substance use disorder professionals, transcultural, and mental health workers working with all age groups and sub-specialties. It will align and link with major Aboriginal and Torres Strait Islander workforce initiatives.

Knowledge Translation Hub utilising new technologies to enhance knowledge translation and undertake research to inform international best practice in implementation and knowledge exchange. A major focus is training in the use of digital technologies in healthcare

Key Priority

Workforce capacity building and skills training, for evidence based and human rights-based implementation, leadership, fidelity monitoring, evaluation and research. Skills development in evidence-based interventions and service delivery systems for all mental health conditions and across all age groups.

Value-add

This Institute will not compete with professional courses conducted by tertiary educational institutions leading to degrees as graduates in the relevant professions, including medicine, nursing, psychology, social work, occupational therapy, rehabilitation, diversiona, arts therapists but will be available to provide input to those courses. It will endeavour to develop relevant but missing tertiary level degree courses where they don't exist, where possible in partnership with existing tertiary educational institutions. A key development area is the integration of technology in health care.

The Australian National Institute of Mental Health

Will provide an Australian-first synergy, bringing together the major innovators in workforce training with implementation and translational researchers currently working independently across disorder silos (eg. addiction, depression, suicide, anxiety, psychosis, psychosocial & cultural trauma, and stigma) to share skills, harness new technologies to develop and trial & ensure faithful implementation of

innovative evidence-based primary to tertiary prevention, early intervention, treatment and care programs for mental disorders and substance use, physical illnesses, developmental, learning and cognitive disorders, criminal justice and corrections related conditions and other co-occurring disorders.

It will be available to all workforces of services for mental health and co-occurring disorders, including:

- transcultural, rural-remote, first responder, e-health, forensic (corrections), and in-person public, private and NGO services.
- It will link with existing indigenous workforce development.
- It will also provide evidence-based training in cost-effective mental health promoting, prevention, and appropriate help-provision strategies for all sectors beyond health, including education, employment, social services, housing, justice, and commerce, whether operated by governments, employers or professional organisations.
- It will ensure, that these organisations will synergise with mental health services, to make a significant contribution to improving mental health, suicide prevention,economic participation and productivity.

Program Features

- Cost-sharing and outsourcing arrangements will be negotiated.
- Expertise in Training, Supervision, Mentoring and Leadership will be provided in Mental Health, Substance Use and all Co-occurring disorders services alongside expertise in both evidence-based clinical and support interventions.
- The Institute will build its capacity to translate the evidence into public health policy, routine workforce training, everyday practice, service evaluation and implementation research.
- Our program will be guided by the active involvement of service-users, their families, and other key-stakeholders, at all stages of the implementation, research and translation process, and a key function of the Australian National

Institute of Mental Health will be building the capacity of peer service-users in recovery and family carers to be both service providers as peer workers in interdisciplinary teams, active investigators and partners in service implementation research and evaluation.

Track Record

Initial partner organisations are the developers of:

a) **National MHS Mapping Atlas, National Standards for Mental Health Services** and the **National Practice Workforce Standards** (see below).

b) **The Essential Components of Care (ECC)**: the most comprehensive national evidence-based mental health service planning tool so far developed for Australian conditions. It is potentially the keystone for:

- evidence based and service-user congenial reform, rational planning and assuring fidelity in practice.
- providing a framework to which resources can be clearly attached and devoted, and service systems can be comprehensively audited for both quality and quantity of care and resource expenditure/acquittal.
- Specifying a menu or potential repetoire of evidence based interventions and service delivery systems for all mental health & substance disorders for all age-groups.
- Enabling regional mental health commissioning authorities to then choose priorities from a menu of the most evidence-based and promising interventions and service delivery systems.
- Ensuring a balance & integration between in-person and e-health or telehealth interventions & sub-systems (eg. e-health for wider access, triage, milder & non-complex disorders; and in-person, mobile outreach, family & team intervention systems for severe & complex disorders).
- capable of being strongly aligned with:

i) National Mental Health Planning Framework, following

transparent appraisal, when it is ultimately released for scrutiny.

ii) **National MHS Mapping Atlas**, which can pinpoint service duplications, overlaps and gaps, and decipher service contexts and complexities to allow full comparison with both international and national best practice services, using large datasets. It can compare resources against crucial mental health and suicide outcomes for different countries and regions, and provide recommendations regarding the staffing, skill sets, service contexts and facilities required to provide optimal services.

iii) The **National Standards for Mental Health Services**, revised 2010, the National Quality of MH Service Accreditation process, the **National Practice Standards for the Mental Health Workforce**, 2013, all of which require updating, and the more recent **National Health Safety & Quality Commission Standards.**

iv)Jurisdictional MH Workforce Initiatives: eg. Centre for MH Learning developing standards of training, MH-Pod, being revised currently [Dept Health & Human Services, Victoria] & NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022: A Framework and Workforce Plan for NSW Health Services.

c) **Major Australian Government National Portals** recently launched for the dissemination of evidence-based resources and information to clinicians, policymakers, consumers, parents, teachers and young people and to provide training to clinicians to improve the identification, management and treatment co-occurring substance use and mental disorders. The National Comorbidity Guidelines were developed and disseminated by our team (www.comorbidityguidelines.org) including an innovative online training module. We have also developed the first evidence-informed portal for crystal methamphetamine (*"Cracks in the Ice"*) for clinicians and the general community to access prevention, and early intervention tools to prevent and reduce crystal methamphetamine use.

d) a virtual "**bridge**" between mental health and addiction services (*"eCliPSE"*) that provides a clinical pathway to

care between the traditionally siloed systems, and that brokers access to evidence-based eHealth treatments for comorbid substance use and mental disorders. We have also been funded to build a similar online tool (*"Health-e **Mines**"*) to engage the mining industry in online prevention and early intervention for alcohol and other drug use, mood, stress, and fatigue.

e) **Peer Co-Designed Implementation Research Programs**: Training and engaging peer service-users, family carers and service providers as co-researchers with mentoring and coaching by expert academics in implementation studies and action research.
f) **Centre for Integrating E-Health**
g) **"Djirruwang" Aboriginal Mental Health Worker Training** Batchelor of Health Science (Mental Health) Program, Charles Sturt University and the **Gayaa Dhuwii (Proud Spirit)** declaration and national education program will provide the foundation for dual 'Two-ways" training in both indigenous traditional healing and contemporary evidence-based practices.

Developmental Phases

Phase 1: Establish Institute

Recruit & deploy core faculty. Establish links to training and educational training bodies. Establish Knowledge Exchange Centre and initial support system for Communities of Practice, and engage expertise for development of Training, Supervision, and Implementation Research & Evaluation methods.

Phase 2: Initial Dissemination

Engagement with national stakeholders and establishment of Institute base with all stakeholder organisations across three key state/territory jurisdictions.

Phase 3. National Roll-out

Establishment of institute based with all stakeholder organisations, and across all states & territories, cost excluding jurisdictional cost sharing component, fully operational beginning year 5.

Budget

Phase 1: (Year 1-2) Establishment recruit and deploy core faculty. Cost: $10M

Initial Development of Knowledge Exchange Centre & Communities of Practice Support System,

Curriculum, Training, Supervision, Implementation-Research & Evaluation Resource Materials: engaging and contracting course materials & training & supervision & mentoring expertise from all stakeholder groups. Cost: $10M

Phase 2: (Year 2-4) Engagement with national stakeholders and establishment of Institute base across three state/territory jurisdictions, expanding to all age group services. Cost: $10M

Phase 3: (Year 4-5) Establishment of institute base with all stakeholder organisations, and across all states & territories, expanding to all age group and subspecialty services, excluding jurisdictional cost sharing component fully operational beginning year 5. Cost: $12M.

TOTAL COST over 5 years: $42M

Recurrent pa cost thereafter: $12M plus cost of living & leasing increments, repairs and maintenance.

Please address any comments to:

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Dr. Paul Fanning,

National Advisor for Mental Health, St Vincents de Paul, Australia, former Director, Centre for Rural & Remote Mental Health Research, University of Newcastle, former CEO and Former Director MHS, Greater West Health Area.

Ms. Irene Gallagher

CEO, Being: NSW and National Mental Health & Wellbeing Consumer Advisory Group [CAG], formerly District Manager developing South Eastern Sydney Peer Workforce Program & Recovery College.

Mr Thomas Brideson

Chair, National Australian Aboriginal & Torres Strait Islander Mental Health Leadership Group, CEO Gayaa Duwii National Program, Deputy Commissioner, NSW Mental Health Commission, Co-Chair, National Mental Health Workforce Strategy Taskforce, Commonwealth Dept of Health, Coordinator (on leave of absence), Aboriginal & Torres Strait Islander Mental Health Workforce Program, NSW Ministry of Health,

APPENDICES

Rationale & Methodology

Mental Health and Co-occuring Substance Use Disorders are a leading global cause of burden of disease. The burden is greatest in young Australians. **Every year mental and substance disorders conservatively cost the Australian community over $AUS 40 billion.** This includes alcohol and other drugs [$23.5 billion, 9], anxiety and depressive disorders [$12.6 billion, 10], psychosis [$4.9 billion, 10], and suicide [$1.7 billion, 11]. Suicide rates among young people are at their highest in over a decade, accounting for over one third of all deaths in Australians aged 15-44yrs. The burden of mental and substance use disorders now accounts for 1 in every 10 lost years of health globally. Governments take the lead in addressing this burden, with **investments in health across Australia estimated at $5.4 billion in 2012/2013.** Yet, **fewer than 1 in 4 Australians access treatment, some treatments routinely provided are neither evidence-based nor effective,** and we have not seen the expected gains in the mental health at a population level.

Effective early intervention and treatment can significantly reduce disease burden by halting, delaying, and interrupting the onset and progression of disorders. For example, preventive interventions can lower the incidence of new episodes of major depression by 25% (up to 50% for stepped-care preventive interventions) and can do so cost effectively and timely early intervention for psychosis can prevent transition to schizophrenia and ensure and hasten full recovery. Early intervention is a good investment. It can be progressively implemented in conditions at every phase of the life cycle, and in every stage of most mental and substance use disorders. Studies have shown ***benefit-per-dollar cost ratios ranging from US$2·11 to $42·13, and savings per participant ranging from $1,348 to $31,036.*** New

interventions have been developed, but the delay to implementation in routine evidence-based care is now over 18 years. Sustainable models of workforce development are critical.

A new cohesive, integrated and focussed approach research, knowledge exchange and implementation is critical; one that capitalises on a range of advances in technologies and new models of implementation science.

Substantial barriers that hinder the widespread dissemination of evidence-based interventions include

a) lack of training in professional communities to change their knowledge, skills and especially their attitudes and work culture, and
b) restricted knowledge in the general public and policy arenas.

The focus of this institute on creative, experiential implementation and training models favouring cost-effective interventions, using new technologies and extensive networks has the potential to overcome some of the implementation barriers to traditional approaches. This aligns with Australian Government strategic directions for mental health reform in Australia. We are at the forefront of these developments and have a demonstrated track record of success in this arena. We have particular success in models for complex comorbidity.

We will implement a multi-modal translational model, with a focus on leveraging responsive and flexible technology, targeted towards clinicians, practitioners, support workers, peer professionals, policymakers, and service-users, to facilitate knowledge exchange and to encourage and evaluate the implementation of evidence-based interventions (eg **Knowledge Exchange Center [KEC], Mental Health Commission of Canada).** The **Matilda Institute** University of Sydney, & **NHMRC Translational Centre for Research Excellence**, has used this model successfully to engage these audiences: our webinars attract over 400 participants monthly. **The Mental Health Services (TheMHS) Learning Network** is the largest organisation in Australia focussed on learning skills and knowledge translation in mental health. Each of its annual working conferences focussed on acquisition of evidence-based innovative skills and service systems attract between 300 to 1000 service providers, service users and family carers every year. The Institute will be a unique partnership between practitioners, learning networks, researchers and implementation science.

Communities of Practice

A support system will be provided to encourage the development of regional, jurisdictional and national communities of practice, for teams of each evidence-based component of integrated mental health services. These will provide opportunities for teams to exchange operational tips, to consider emerging evidence together and reciprocate extended peer support. Ample precedents included

separate national in-person and electronic forums for crisis intervention, assertive community treatment, community living skills, community residential teams and early intervention in psychosis teams, originally hosted by Northern Sydney Mental Health Services, and later by TheMHS Conference of Australia & New Zealand, Orygen and headspace.

Knowledge Exchange

Poor communication of research findings is a significant barrier to population-level dissemination. Thus, a strong aim of the Institute is to develop user-friendly packaging of research findings, and increased dialogue between policy makers, researchers, professionals and practitioners. We will focus on practical workforce development, and on technology as critical information currency to directly engage end users, particularly young people.

Education (via professional and public communication, workforce development initiatives): **Professional workshops, seminars and webinars**: Members of the team are affiliated with clinical, e-health self-help, support and research facilities across mental health and addiction, in Australia. We will use these established networks to implement clinician training and workforce development. In line with our established and successful dissemination models, the institute will provide national workshops, seminars, forums, and a webinar series to maximise the reach of new knowledge and programs. **Web and social media platform**: A key component of the translational model will be the development, hosting, and maintenance of a dedicated web and social media hub to disseminate research findings, and advertise, promote, and host other translation activities. Fact sheets, information booklets, practice guidelines, treatment summaries, and manuals to provide strong evidence-based recommendations to improve clinical practice will be disseminated via the website and online portals, and as hard-copy resources where appropriate.

Partial precedents and potential state, national and international partners for this initiative include:

TheMHS Learning Network of Australia & New Zealand, Mental Health Commission of Canada National **Knowledge Exchange Center** [KEC], and International Knowledge Exchange Network for Mental Health [IKEN-MH], with International Institute of Mental Health Leadership [IIMHL] Calgary, Canada, **Royal Commission into Victorian MHS [RCVMHS]**, interim report, 2019, the first and highest priority recommendation of which is the **Victorian Collaborative Centre for Mental Health and Wellbeing**, a potential state based component of this initiative, **Matilda Institute, Research Translational Centre for Research Excellence**, University of Sydney, and **Te Pou o te Whakaaro Nui**, the New Zealand national government funded centre of evidence-based workforce development for the mental health, addiction and disability sectors.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AR-3

This is the attachment marked "AR-3" referred to in the witness statement of Alan Rosen dated 23 July 2020.

POTENTIAL SERVICE MODEL FOR ADULT MENTAL HEALTH CENTRES

CONSULTATION PAPER

July 2020

Contents

Glossary of key terms used in the paper

In general, the terms used in this paper should be understood to align with definitions provided in the Fifth National Mental Health and Suicide Prevention Plan. The following terms are highlighted.

Warm transfer – the Centre actively communicates with the service to which the individual is connected to provide essential information about their needs before transferring them. Support is maintained for the individual by the Centre until they are received by the service.

Clinical governance – Clinical governance is defined as the system by which the governing body (bodies), managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients/residents.

Episode of care - the package of care and evidence-based treatment provided by a Centre, for individuals with a specific mental health need. An episode of care is delivered by members of a multidisciplinary team over a set time period.

Peer support worker – Workers who have a lived experience of mental illness and/or suicide and who provide valuable contributions by sharing their experience of mental illness and/or suicide and recovery with others. Peer workers may have lived experience as a consumer or as a carer.

Care navigator – a person who works collaboratively with consumers and carers to assist them in finding the most appropriate treatment, care or supports.

'Front of house' – the location where the public is received and may wait for services. Front of house services are provided in these public areas.

Local Hospital Networks (LHNs) – entities established by state and territory governments to manage single or small groups of public hospital services, including managing budgets and being responsible for performance in a defined geographical area. LHNs also commonly manage other health services such as community-based health services.

Some jurisdictions have their own local names for LHNs. For example, in New South Wales they are known as 'Local Health Districts', in Queensland they are known as 'Hospital and Health Services', in South Australia they are known as 'Local Health Networks', and in Tasmania they are known as 'Tasmanian Health Organisations'.

Co-morbidity – other conditions that occur at the same time as mental illness. This is often physical illness or poor health but also includes use of alcohol and other drugs. Both are very common in those with mental illness or mental disorders.

Alcohol and Other Drugs (AOD) – this term most often refers to excess use of alcohol and misuse of illicit or prescribed drugs.

Introduction

As part of the 2019-20 Budget, the Australian Government announced it will invest $114.5 million over five years to undertake a trial of eight Adult Mental Health Centres (the Centres), with one to be established in each state and territory. Through the 2019 Mid-Year Economic and Fiscal Outlook process, funding has been brought forward to enable the South Australian Centre to be established in mid-2020, and to enable the remaining seven Centres to be established from 2020-21, with service delivery to commence in 2021-22.

This paper has been prepared to support consultation on a potential approach to the model of service offered through the trial of the Centres. A Technical Advisory Group was established to advise the Department on the initiative. The paper outlines the key assumptions underpinning the model of service, explores how individuals with different needs might access services from the Centres, and proposes services that would be needed in-house as well as on referral. It also considers workforce, flexibilities allowed in the model, and essential safety and quality issues. The paper is provided for comment as part of an iterative process of development of the Centres and will help to inform the trial.

The Centres are designed to provide a welcoming, low stigma soft entry point to engagement and assessment for people who may be experiencing distress or crisis, including people with conditions too complex for many current primary care services but who are not eligible for or awaiting care from state or territory public community mental health. They are also intended to trial approaches to offering immediate, short and medium term episodes of care and service navigation to connect people to ongoing services. They will assist adults seeking help in times of crisis, or as needs emerge, to have access to on-the-spot treatment, advice and support provided by a variety of health professionals – without needing a prior appointment.

The Centres are intended to complement, not replace or duplicate, mental health services already provided in the community. They are not designed to offer longer term care but will be based on an episode of care model, delivering packages of evidence-based care and family support to cover the short to medium term, which could last from a few weeks to several months. Centres are to provide an accessible, responsive service that meets immediate needs and provides expertise in assessment of needs, linkage and support, and treatment. Centres should also provide integrated mental health and AOD services.

Through the trial, the Centres are to be commissioned in all states and territories except South Australia through funding to the corresponding Primary Health Networks (PHNs). As part of their commissioning processes, PHNs will undertake further consultation, at a local level, with consumers, carers, Local Hospital Networks (LHNs) or their equivalent and other local stakeholders to co-design and shape services to meet the particular needs of the area, within the framework presented by this model. Whilst, over time, the Centres may meet a range of special needs within the region, a key imperative will be ensuring the model of care offers a culturally safe response to the needs of Aboriginal and Torres Strait Islander people, in line with the principles of the Gayaa Dhuwi (Proud Spirit) Declaration.[1]

Summary of the key elements of the model

The model of service will seek to address key gaps in the system by:

- Providing a highly visible and accessible entry point to services for people experiencing psychological distress, where all feel safe and welcomed;

[1] Available from http//natsil.mh.org.au/sites/default/files/gayaa_dhuwi_declaration_A4.pdf

- Offering assessment to match people to the services they need;
- Providing on the spot support, treatment and advice without prior appointments or out of pocket cost. Every interaction should be with the intention of therapeutic benefit; and
- Offering an episode of care model based on short to medium term multidisciplinary care, aimed at stabilising symptoms for people with moderate to high levels of mental health need, whose needs are not being met through other services.

The service model will need to address the following four service elements:

- Respond to people experiencing a crisis or in significant distress, including people at heightened risk of suicide, providing support that may reduce the need for emergency department attendance;
- Provide a central point to connect people to other services in the region, including through offering information and advice about mental health and AOD use, service navigation and warm referral pathways for individuals, and their carers and family;
- Provide in-house assessment, including information and support to access services; and
- Provide evidence-based and evidence-informed immediate, and short to medium term episodes of care, including utilisation of digital mental health platforms.

Assumptions underpinning the service model

- Centres will welcome adults experiencing emotional distress, crises, mental ill health, and/or addiction, and their families and carers through a 'no wrong door' approach.
- Young people aged 12-25 years old should be encouraged to seek access and ongoing care and support from more appropriate and youth friendly services such as headspace services and other services targeting the needs of young people.
- Centres should offer a holistic approach to care, addressing a broad range of social, physical and emotional needs, supported by best practice in evidence-based and evidence-informed care. This should include integrated care for people concerned about AOD use which coexist with mental ill health and culturally appropriate best practice.
- Centres should be required to provide or facilitate core functions within an agreed framework, in a way which complements and does not duplicate existing services, including acute or long term services.
- Centres must adhere to the principles of the Gayaa Dhuwi (Proud Spirit) Declaration in the development and delivery of services to ensure culturally safe services for Aboriginal and Torres Strait Islander people are included as part of the broader model.
- Centres should have some flexibility for regional variation, over time, to address other cultural or local population needs and to make optimal use of already available services. This includes opportunity for the development of innovative approaches to complement core services provided through Centres.
- Centres should be promoted as supporting people at times of crisis and distress, and not in terms of language of mental illness.
- Centres will connect people to pathways to less urgent longer-term care. The Centres are not expected to provide services of an ongoing nature, but will have capacity to provide short to medium term targeted treatment and support.
- Centres should promote optimal use of digital mental health and AOD services, including integrating digital forms of support into treatment plans and supporting their use.
- A quality framework should support the model of service, including by ensuring the risks of supporting individuals who may be experiencing high distress are managed, and attending to appropriate ongoing support, supervision and training for all staff, including peer support workers.

A highly visible and accessible entry point for individuals and those providing support to them

The physical environment of the Centres should be calm, safe, friendly and welcoming to individuals experiencing emotional or psychological distress and to family and carers who support them. Centres should feel welcoming and safe to all who present, including Aboriginal and Torres Strait Islander people, people from diverse cultural backgrounds and LGBTI people. In addition, it is important that the Centres provide a safe entry point to integrated care for people who present concerned about their AOD use. Centres should be in a location easy to reach by public transport. They should be relatively close to a major hospital and/or to other health services, so a close relationship with crisis teams can be developed, and to facilitate their role of offering an alternative to emergency department attendance, where appropriate.

Centres must be open extended hours in order to be available to people when they are experiencing distress. Centres should enable access to support and advice seven days a week, and after hours, including through provision of a digitally based contact point for people experiencing distress at times the Centre itself is not physically open. Opening hours may be adjusted in response to demand experienced through the trial and to complement availability of other regional services.

Centres will have a "front-of-house" function where people can seek information and assistance navigating services by visiting the Centre, and potentially also by digital means through telephone or internet. A digital presence for the Centre may also include provision of computers on site and assistance accessing a range of digital information and mental health services. This could include low intensity on-line services such as Head to Health or other self-help or clinician supported digital interventions for mental health and/or problems related to AOD use.

Whilst people are waiting for services at the Centre, staff, including peer support workers, will be available to check in with them, and provide support if needed. People seeking information or resources rather than services, including family members or carers, will be welcomed at the Centres and supported to get the information they need. It is intended that support and interventions will be provided over a short timeframe for most people so that long wait times and waiting lists are avoided. It is recognised that for some people there will not be readily available services to which they can be referred, and in these circumstances targeted medium term treatment may be appropriate, particularly whilst waiting for longer term or specialist treatment.

Assessment

Those requiring more than information or assistance navigating available services will need to be provided with an assessment of their needs. Current projects, such as the Department of Health's Initial Assessment and Referral Project[2], will be useful in considering a consistent approach to assessing need and connecting people to the services best able to respond to that need.

[2] The Initial Assessment and Referral Project, is an initiative of the Australian Department of Health and aims to provide advice to Primary Health Networks (PHNs) on establishing effective systems for the initial assessment and referral of individuals presenting with mental health conditions in primary healthcare settings

An initial brief review of needs should be undertaken at the point of accessing the Centre to identify whether individuals need urgent support, and to determine what the main focus of support is likely to be. In particular, all staff involved in initial intake, or who play a role in supporting clients while waiting, should be trained to recognise an individual who may need urgent support and who should be 'fast-tracked' to a clinician. Clients of the Centre should not be required to go through two stages of assessment, nor tell their story more than once within the Centre. It is expected that the clinician who first sees the person will make clinical judgements on the most appropriate interventions and in many cases also be the professional to deliver the episode of care. At times they will need to seek the particular expertise of other team members. It is expected that a number of clinicians at the Centre will have experience and expertise across mental health, AOD and physical health, given the prevalence of these problems amongst the population likely to present.

For those presenting with significant distress, or with acute needs which require urgent medical attention beyond the capacity of the Centre, protocols will be developed with the LHN for urgent review and referral. This may include immediate communication with, or warm transfer to, emergency or acute services where this is needed. Immediate support will be provided by staff at the Centre to help de-escalate symptoms and ensure people and their families feel safe. The Centre may form an agreement with the local acute mental health service for prompt in-reach support.

The assessment and referral process will determine the level of service a person requires, and treatment to be provided. It will inform development of a care plan where appropriate, and identify those individuals who would benefit from service navigation. Centres will ensure that the physical health needs of people with more severe mental illness are assessed, and that drug and alcohol comorbidities or risks of substance misuse are routinely assessed. Where substance use is a significant component of the presentation, professionals with competency in identifying and managing substance misuse issues, including addiction specialists, should be involved or consulted in assessment processes and subsequent treatment plans. Where physical health needs are prominent (e.g. people with co-occurring chronic illness), the Centre should assist in organising an early appointment with local primary health services. It is anticipated that some Centres may develop local arrangements for medical services and other services able to be billed to Medicare to be provided in-house, within the clinical governance of the Centres as outlined below. The assessment process will also consider non-health factors which would both impact and be impacted by distress levels including a lack of adequate, stable safe housing, domestic and family violence, low socio-economic status, a history of trauma, and past experience of high levels of discrimination and stigma.

Core services to be provided by Centres

To provide the elements of the service model, there are a number of services which all Centres would be reasonably expected to provide 'in-house', using available funding. In addition there are a number of important services and supports upon which the effectiveness of the model depends, which Centres are expected to either offer in-house, **or** offer through seamless referral pathways and partnerships with other agencies.

Core services to be provided **'in-house', using funds available to the Centres**, to address the key four elements of the service model, must include the following:

1. Responding to people experiencing a crisis or in significant distress:

- Immediate support to reduce distress for people experiencing crisis or at risk of suicide presenting to the Centre, to help them feel safe and stabilise symptoms before ongoing management within the Centre, or arranging warm transfers to other services where appropriate (see also flexibilities); and
- Support for communities and individuals experiencing significant distress associated with times of natural or other disasters.

2. Providing a central point to connect people to other services in the region:

- Information for individuals, families, friends and carers on locally available mental health, AOD and suicide prevention services, and related social support services;
- Support and advice for families, friends and carers to assist them in their role, and acknowledge their social and emotional support needs; and
- Service navigation, supporting clear and seamless pathways, including access to digital self-help services, and providing a point of contact and follow-up.

3. Provide in-house assessment, including information and support to access services:

- Assessment and initial review to ensure people are matched to the services they need, including assessment of physical health needs, problems related to AOD use, and other social factors or adversity which might impact on their mental wellbeing.

4. Evidence-based and evidence-informed immediate, and short to medium episodes of care:

- Initial information provision, comfort and containment of symptoms, including, where possible, those related to alcohol and drug use;
- Short to medium term support and treatment, based on an episode of care model, whilst individuals are recovering or are waiting to be connected to longer term or more appropriate services and support, including regular contact and follow-up with individuals at heightened risk of suicide and their families and carers; and
- Digital mental health services and information, including promoting access to on-line therapies (such as those offered through Head to Health) and clinician-supported digital interventions for mental health and problems related to AOD use.

Centres will also ensure that the following core services, which are essential to the integrity of the model, are available to people who present to the Centre, either on an **'in-house', 'in-reach' or referral basis**. Most of these services would be provided under the clinical governance of the Centre, particularly where funded on an in-reach or in-house basis:

- Medical assessment, including initiation or continuation of medication management where appropriate; and assistance with physical health needs from GPs, or psychiatrists;
- Structured psychological therapies such as cognitive behaviour therapies, including services provided through Medicare Benefits Schedule (MBS) arrangements;
- Specialised suicide prevention follow-up services, such as the Way Back Support Service;
- Assistance identifying and managing comorbid substance misuse from addiction specialists;
- Integrated vocational support services such as Individual Placement and Support (IPS);
- Assistance managing stressors associated with high levels of distress, including financial problems, civil and criminal legal issues, family support, accommodation instability and social isolation;
- Culturally safe services for Aboriginal and Torres Strait Islander people;

- Connection to peer-led services such as peer networks, support groups, or phone lines; and
- Other services which are essential to the integrity of the model, depending on the particular geographic, cultural and service needs of the region (see flexibilities below).

The mix of additional services which the Centres provide in-house may vary from location to location, and will depend on arrangements negotiated with LHNs and other local services to ensure complementarity and to focus available Centre funding on addressing gaps. Some Centres may focus on providing a platform for in-reach services to be offered, including services from GPs, psychiatrists or other MBS funded providers.

What services are out of scope for the Centres?

To ensure demand management, and ensure capacity for new people to present, Centres will not generally provide longer term or ongoing mental health treatment or support services.

Centres will provide immediate support and clinical interventions to help individuals become stabilised before referring them to other longer term services, if required and where these are available. It is recognised that for some people there will not be readily available services to which they can be referred, and in these circumstances targeted medium term treatment will be appropriate as an episode of care. Those individuals who are referred will be actively connected to these services and may return to the Centres for further navigation support, or for review of their needs.

Centres are not funded to provide:

- Services for people in need of urgent emergency department care;
- Acute reception of police or ambulance referrals;
- Pathology, radiology or pharmacy services;
- Ongoing, long term psychosocial support or recreational services;
- Direct financial support;
- Residential or bed-based services;
- Services targeting children and youth under 25 years old (which could be provided more appropriately by headspace or other specialised children or youth mental health services;
- Disability support services provided through the NDIS (although the Centre will assist with referral to the NDIS and related information);
- Other services which are provided by other agencies in the area (see referrals below).

The role of the Centres in providing care to people with moderate to high levels of mental health need

The Centre's role in relation to supporting people with moderate to severe levels of mental illness should focus on providing an episode of care which aims to support the individual and to assist them to navigate the health, mental health, and broader social services which they need over the long term.

Centres may include a short to medium term service offer for people with moderate to high levels of need, where there are no available services appropriate to their needs to which they can be referred, or whilst they are waiting to be connected to longer term care. However, if Centres are to continue to be accessible, and have capacity to deliver immediate

support, they will need internal protocols to assist in demand management. The Centres are expected to have a limited role for those with enduring, long term needs.

An appropriate role for Centres for supporting people with moderate to high levels of mental health need should include:

- Provision of immediate care for people with moderate to severe mental illness who present in distress or suicidal crisis;
- A full assessment of their mental health and other needs including co-occurring substance misuse or physical health issues which may influence their needs;
- Provision of short to medium term treatment according to an episode of care model, for people for whom there is no other service available. This should deliver a limited package of services through a multi-disciplinary team arrangement designed to address their mental health and related needs;
- Warm referral to more specialised services and longer term psychosocial support where individuals require ongoing, long term care;
- The provision of continuing assistance with care navigation to individuals who are experiencing moderate to severe levels of psychological distress, to ensure they are not left without services; and
- Connecting family and/or other carers with services that can support them in their roles.

Centres should not provide ongoing long term care, nor replace the role of state/territory community mental health services in providing services to people with acute needs. In some circumstances, individuals may present who are the clients of existing services, including state/territory community mental health services. Whilst immediate care should be provided, Centres should support these individuals to reconnect with their regular services.

The evaluation of the trial of Centres and the ongoing monitoring of the role they play in this area will be useful to inform adjustment of the model of service to appropriately meet the needs of this group in a way which does not duplicate the role of other services, yet which helps to address the gap in services for people with more complex needs.

The role of the Centres in providing care to people who present with significant levels of distress or suicidal crisis

Centres are intended to help address the service gaps which currently exist for people experiencing high levels of distress or suicidal crisis. In addition to providing a safe place to present for people experiencing high levels of distress, or who are at heightened risk of suicide, the Centres will also offer continued contact and follow-up support through an episode of care model until these individuals are either in recovery, or connected through warm transfer to services to meet their ongoing needs.

Precedents through initiatives such as the Safe Haven services, have shown this can successfully divert people from less appropriate emergency department attendance, and promote better outcomes, where urgent emergency department care is not required. These services rely on good cooperation with emergency departments and community-based front line services and acute mental health services to support throughput and ensure safety for clients and staff.

Protocols for this function of the Centre will need to be refined in partnership with the LHN and emergency departments to:

- Ensure swift identification of those individuals who are experiencing a crisis, and provision of immediate support and comfort to them and their family or carers;
- Identify and refer individuals whose needs cannot be met appropriately in the Centre. This may include the care of individuals who are at risk of harm to themselves or others;
- Identify individuals experiencing heightened distress who are intoxicated or under the influence of licit or illicit drugs, and swiftly decide whether or not their needs can be appropriately and safely met at the Centre;
- Have in place clear arrangements for crisis support and transport to emergency departments when urgent referral is needed; and
- Centres will also need to have capacity to discretely provide care for individuals in heightened distress, in a way which protects their privacy and does not impact on other clients of the service.

In some locations there may already be services in place nearby which offer a safe and person-centred, friendly alternative to presenting to hospital. In these circumstances, Centres may wish to partner with these services, rather than duplicating the service, and focus available funds on other aspects of the service model to better address service needs in consultation with LHNs and other key stakeholders.

Referrals

Smooth referral pathways, which are seamless for people requiring support will be essential to the effective operation of the Centre's model. This must include capacity for warm transfers, particularly for people experiencing high levels of distress who require long term care, to enable new entries to the service. Through warm transfers, the Centre actively communicates with the service to which the individual is referred to provide essential information about their needs before transferring them. Support is maintained for the individual by the Centre whilst they are waiting for an appointment with the agency to which they have been referred.

Services to be provided on referral, where it is not possible to provide these services in-house or through using the Centre as a platform, may include:

- GP management of ongoing physical health issues;
- Private MBS funded psychiatry or psychological services;
- headspace services or child mental health services (noting warm transfers will also be appropriate to ensure people under 25 are connected with the new service);
- Other services commissioned by PHNs, including psychological services, Aboriginal mental health services, or services targeting the needs of hard to reach groups;
- Services providing mental health or broader support services for Veterans;
- Warm transfers to state or territory government funded acute and emergency care, and public and private hospitals;
- Public and private specialist mental health services;
- Services meeting particular needs such as perinatal depression, eating disorders, or early psychosis;
- Specialised support networks and or physical health support services;
- Social support services, including housing, employment, child and family support and income support;
- Legal aid services or forensic mental health support services;
- Specialised Alcohol and Other Drug services (where ongoing support is needed as opposed to integrated support for comorbid substance misuse at the Centre);

- Disability support services, including support through the National Disability Insurance Scheme and Information, Linkages and Capacity Building (ILC) programs; and
- Peer support groups, and peer led safe spaces.

Partnerships and protocols

Close partnerships will be formed with the services described above as appropriate to enable an integrated approach to individuals who may require transfer from one service to the other. In particular, clear protocols will be developed for the interface between the Centres, the PHN and the LHN and its emergency departments to enable a seamless transfer of patients when needed. It is anticipated that some people who present in crisis at the Centre may have existing care arrangements with LHN mental health services.

As part of this it is expected that protocols developed with local services will provide clarity on what sort of presentations are likely to require emergency department attendance, and which individuals experiencing distress can be appropriately supported within the Centres.

As many individuals presenting to the Centre may already be clients of other services, including public and private specialist mental health services, protocols for communicating with and if appropriate providing shared care with these services will also be important. Each Centre will also need to have good systems with other local providers for referral and coordination of care. It will be important that services are not duplicated and that information is shared among providers (with consent) to minimise the need for repeated explanation by consumers and carers. The use of My Health Record should be considered to facilitate communication and coordination. In general, wherever possible, efforts to co-locate services at the Centre should be pursued to support a 'one stop shop' approach. This is most likely to avoid fragmentation and retelling of stories.

Workforce – a multidisciplinary team approach

To deliver the core functions of the Centre, it is expected that Centres will establish multi-disciplinary teams, supported by appropriate clinical governance – both within the Centre and where there are shared care arrangements. Services provided will need to be recovery focused, trauma informed and person-centred. The core workforce may be supplemented by practitioners providing services funded through MBS items.

A multidisciplinary team approach allows the opportunity for clinicians and peer support workers, and/or staff with dual expertise across mental health and AOD, or with expertise in delivering digital mental health services or particular cultural expertise, to utilise their particular skill sets while also functioning as an integrated team with shared clinical review and team support.

However, not everyone presenting to the Centres will require multidisciplinary care. Individuals with high levels of distress, or complex needs will most benefit from having access to a small team whilst they are in the care of the Centre (e.g. mental health nurse, psychologist and peer worker). On the other hand, many individuals with lower levels of distress will prefer to receive, and may only need support from one professional. Similarly, it would not be efficient to expect Centres to establish an extended multidisciplinary care team in-house, including specialists, to meet the needs of all clients.

Centres should seek to establish partnerships with GPs, emergency department staff and other external professionals, including MBS funded private service providers, to enhance a multi-disciplinary team approach to meeting needs, without duplicating available services.

There may also be shared employment arrangements with LHNs, including possible secondments, and potential for sessional in-reach services to enhance the spread of skill and expertise within the team.

Table 1 – Possible Multidisciplinary Team Members

Core function	Skills or competencies	Possible multidisciplinary team members
Providing a central point for connection and service navigation	Knowledge of local services Knowledge of digital services Capacity to identify and provide reassurance to individuals in distress Skills in care navigation	Peer support workers Mental health nurses Allied health professionals Care navigators
Providing an option for intervention and support to reduce the need for emergency department attendance	Ability to de-escalate high levels of distress Capacity to identify individuals requiring acute emergency department care Medical skills, including knowledge of medication	Clinical psychologists, social workers or other allied health professionals with mental health competency Mental health nurses Medical staff (GPs and/or specialist psychiatrists and registrars) Peer support workers AOD professionals or staff with dual competency Aboriginal health workers
Assessment (noting a single professional would be likely to undertake an individual assessment, but may seek support and advice from other team members)	Skills in using the Initial Assessment and Referral (IAR) tool or similar model Competency as a mental health professional Ability to assess physical health needs and or AOD support needs Ability to assess suitability for digital support and treatment options	Mental health nurses Clinical psychologists, social workers or other allied health professionals with mental health competency Aboriginal health workers AOD professionals and GPs
Providing treatment and support for individuals, families and carers (noting a single professional may meet the needs of some individuals, whilst a team approach to care could be required for people with complex needs)	Skills and training in providing interventions or psychosocial support Competency as a mental health professional Competency in providing AOD support Competency in providing or supporting digital treatment options	Psychiatrists and registrars Addiction specialists GPs Social workers or other allied health professionals with mental health competency Clinical psychologists Mental health nurses (scope for nurse practitioners) AOD professionals Peer support workers Aboriginal health workers Transcultural health workers Vocational support workers

Given the role of Centres in offering an option for intervention and support to reduce the need for emergency department attendance, staff will need to be available who have received specialised training and who are experienced in supporting people at risk of suicide or who are experiencing significant levels of distress. In addition, all staff who provide "front of house" functions and support initial intake of people should be trained in ways to help support individuals experiencing distress, and to identify people requiring urgent treatment. It is anticipated that the Centre manager will have both clinical and operational expertise. Staff should have appropriate support or supervision arrangements in place.

Flexibilities

In general, Centres will be required to provide a reliable model of service consistent with the national framework and branding, and offer a minimum central suite of services as outlined earlier in this documents. However flexibilities will be allowed to address regional variation including the following:

- Adjusting any additional service offering to ensure that the Centre is complementing and not duplicating existing services in the region;
- Addressing particular cultural needs of the region, such as the needs of Aboriginal and Torres Strait Islander people, and the needs of people from diverse communities within the region including LGBTI people;
- Potential to adapt or share workforce in areas of reduced availability, for example sharing scarce professionals such as psychiatrists and mental health nurses with hospitals or other state or territory government services;
- Some Centres may wish to offer opportunity for external entities to provide services using the Centres as a service platform, to offer more of an in-house service offering and make best use of resources;
- Flexible approaches to providing access over extended opening hours may be utilised to make the best use of limited workforce, and complement other services in the region. Centre opening hours may vary in this respect; and
- Making arrangements with professional training programs to utilise and where required, offer supervision to students and junior professionals in training, including those at Probationary and Registrar levels, and those preparing for peer support worker roles.

Flexibilities in focusing investment would be determined through a process of mapping existing services, negotiations with local state or territory government service providers and other stakeholders to focus on gaps and avoid duplication. This should build on and utilise mapping exercises, and knowledge acquired for joint regional mental health planning purposes. For example, if the LHN already funds an alternative mental health service or safe space for people experiencing crisis who otherwise would present at hospital, the Centres may instead focus on enhancing other complementary aspects of the service model, and partner with the LHN service in offering seamless referral pathways for consumers.

Centres are encouraged to explore partnerships with other agencies for the development of innovative service options to complement the Centre's core functions.

Integration and planning

Each individual Centre will be established within a service landscape, which is likely to be unique. The mix of state and territory government, non-government and PHN funded mental health and social support services, which may be available, will vary. This makes it very important that Centres should be carefully planned, mapping available services to

ensure core functions are provided in a way which makes the best use of available resources.

In general to achieve appropriate integration and planning, Centres will need to:

- Map available services;
- Consult with other agencies, services, and consumers and carers about service gaps and needs;
- Ensure appropriate information is shared between the Centre and other agencies about roles and relationships;
- Share experience and learning across Centres in different jurisdictions;
- Negotiate pathways and protocols for integrating services;
- Identify risk of service duplication, or confusion to consumers about overlapping service intent; and
- Consider opportunities for co-design and co-commissioning.

Safety and quality

A comprehensive safety and quality framework will be required as part of the implementation of the Centres. This should include the following:

- Compliance with relevant safety and quality standards, including the National Standards for Mental Health Services 2010;
- Implementing appropriate confidentiality and privacy arrangements in accordance with relevant legislation, whilst ensuring appropriate information sharing is in place between services involved in a care pathway to support quality care;
- Clinical governance to ensure that staff are appropriately credentialled, well supported and trained to provide care to people experiencing crisis. Protocols must be in place to guide review of the care provided and for responding to critical incidents and complaints;
- There should be clear lines of accountability within the Centre;
- Protocols to ensure the safety of staff and clients in the event that an individual presents a risk to themselves or others;
- Protocols with other relevant organisations, for example LHNs and their services, to ensure that offering alternative services to those offered in acute settings does not result in a delay in providing urgent services or otherwise risk the safety and wellbeing of individuals;
- After hours arrangements that include provisions to ensure staff and clients are not at risk and are equipped to discretely manage the care of individuals who are intoxicated or exhibiting anti-social behaviour associated with illicit drugs (e.g. arrangements in place with police, minimum after hours staffing levels);
- Consideration in general of safety and quality priorities outlined in the Fifth National Mental Health and Suicide Prevention Plan;
- Cultural safety considerations to ensure that Aboriginal and Torres Strait Islander people receive quality responses and equality of care;
- Support for carers which is timely, responsive, appropriate and accessible, in line with the *Carer Recognition Act 2010*; and
- Support for the appropriate use of the *Privacy Act 1988* and the Australian Privacy Principles, so information can be shared by practitioners as part of effective collaboration with consumers and carers.

Pathways to care

Pathways to care and support within the Centre will be different, depending on whether individuals seek information or connection to other services, in-house assessment and treatment services, or are experiencing significant distress or crisis. Pathways should also be in place to ensure family and carers seeking information, and potentially emotional support, are appropriately supported. A possible, broad pathway to care is outlined in Attachment A.

This pathway presumes the following broad elements:

- Initial contact – by phone, on-line, walk-in or referral from other services;
- Initial brief assessment of needs to identify whether need is for information for self or others, for mental health services or for crisis support;
- Provision of immediate support and assessment if appropriate;
- Provision of short to medium term treatment targeted to need to enable support until the individual is connected to longer term care;
- Liaison and referral with agencies to whom the individual is referred; and
- Review and, if required, follow-up.

Phased implementation

The Centres will be a new addition to the existing regional service landscape, and will face a number of local implementation challenges in addressing service gaps including:

- Planning services to complement, and not duplicate available services in the region;
- Managing demand in a way which enables access to immediate support and advice for all who present, whilst also providing short to medium term episodes of care for those for whom services are not available;
- Building a skilled multidisciplinary team in the context of likely workforce shortages;
- Identifying and where possible meeting unmet special local or cultural needs whilst also having a standard suite of services;
- Offering after hours services, including a level of crisis support, in a way which is sustainable from a duty of care, workforce and budget perspective; and
- Developing partnerships needed to offer a range of services and referral pathways.

To allow time to address these challenges, a phased approach to implementation of Centres is proposed. These phases are likely to include:

- An establishment phase, which will be informed by consultation, needs assessment, local service mapping and existing joint regional mental health planning processes before opening for service delivery. This should include establishing a mission and culture, agreeing principles underlying the model of care, and providing initial inter-disciplinary training and supervision;
- An embedding phase, where a basic core suite of information, services and referral pathways is established and delivered, and partnerships are developed. This may, for example, involve focusing on provision of core in-house services such as the capacity to provide immediate information, advice and support and service navigation; and
- A full implementation phase, through which additional partnerships to support in-reach services or more specialised support to address local need is offered.

A process of iterative review between phases, including continuing consultation with key stakeholders, will help to shape the role of Centres to deliver a basic suite of services and locally appropriate additional services to optimally complement existing regional services.

Evaluating the service model provided through the trial

In broad terms, the following outcomes for consumers and carers are expected from each Centre funded through the trial:

- People requiring support in the area, or those attending the Centre, will recognise the Centre as an accessible entry point to the mental health care system for the services and information they need.
- People will be able to access through the Centre, or be connected to by the Centre, the particular mental health and related services they are assessed as needing.
- People will receive immediate advice and care which will reduce their level of mental and emotional distress.
- Individuals experiencing high levels of psychological distress or in crisis will receive the care they need from the Centre, resulting in a reduction in the number of non-urgent presentations to local hospital emergency departments.

An evaluation framework for the trial is being developed, with the assistance of the Technical Advisory Group, to support monitoring and review of the effectiveness of the model of service in achieving these outcomes, and to inform future expansion of the initiative.

Attachment A

Patient pathways within the Centre

Initial contact and intake	By phone, on-line, walk-in, or referral from other service (e.g. GP, hospital, state/territory service)		
Initial brief assessment of needs	**Information for self or others**	**Mental health service needs (non-crisis)**	**Crisis services (alternative to emergency department)**
Immediate support and assessment if appropriate	Connect with information and services. Support and advice for families, friends and carers	Assessment undertaken to identify level of need and/or referrals required, using Initial Assessment and Referral decision tool, or similar. Initial support provided. AOD use and physical health assessed. GP advised patient is receiving services.	Immediate support to de-escalate and; • Support in-house • Supported transfer to home/carers • Warm transfer to acute OR • Full assessment following stabilisation as per non-crisis.
Short to medium term treatment and episode of care according to need	Support to access digital information and treatment services relating to mental health and/or AOD needs	Support and short to medium term therapeutic treatment, based on an episode of care model, whilst individuals are waiting to be connected to longer term services and support if needed. For some individuals this short term support may be enough to resolve distress, supplemented with digital treatment services or family support.	Support and short term targeted therapeutic treatment, based on an episode of care model, including while waiting connection to longer term support. Regular contact and time limited follow-up with individuals at heightened risk of suicide and their families and carers, including by digital means.
Service navigation and referral		Service navigation to assist them to connect to services and supports. Warm referral to relevant services.	Service navigation and option of review Warm referral to relevant services Referral to Way Back or other follow-up services if risk of suicide
Review		Follow-up and review.	Follow-up and review.
Enablers	Partnerships, clear protocols with state/territory services, multi-agency care planning, skilled workforce, clear roles, supported pathways.		

Attachment B

Adult Mental Health Centres Principles

The Australian Government is funding a trial of eight Adult Mental Health Centres across Australia. The Adult Mental Health Centres will be developed and operate at the local level under the following guiding principles. The Centres will:

1. Offer a highly visible and accessible 'no wrong door' entry point for adults to access information and services which are designed to empower, support and improve their psychological and physical health, and social and emotional wellbeing.
2. Provide information and services which can assist those providing support to people in need.
3. Provide a welcoming, compassionate, culturally appropriate and safe environment that is inclusive for all people accessing services or support.
4. Provide access to best practice on the spot advice, support and treatment for immediate, short term, and where appropriate, medium term needs delivered by a multidisciplinary professional health care team including a suitably trained peer support workforce, nursing and allied health and specialist medical care, without prior appointments or a fee.
5. Assist people in need to find, access and effectively utilise digital forms of help including information, support and therapies.
6. Support people to connect to pathways of care through integration with longer term existing community mental health services where these are accessible, local Primary Health Network commissioned services, or GPs and state and territory funded services, as required.
7. Provide an option for intervention and support that may reduce the need for emergency department attendance.
8. Explore opportunities for the development and utilisation of innovation to complement defined core functions.
9. Implement appropriate confidentiality and privacy arrangements in accordance with relevant legislation.
10. Operate under robust effective governance frameworks and conduct local evaluation activities, to ensure transparency and accountability and maximising service quality.

The establishment and implementation of the Adult Mental Health Centres trial will be nationally evaluated to generate new evidence and to guide any future expansion of this initiative.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AR-4

This is the attachment marked "AR-4" referred to in the witness statement of Alan Rosen dated 23 July 2020.

Transforming Australia's Mental Health Service Systems (TAMHSS)
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Response to the Productivity Commission Mental Health Inquiry Draft Report

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Mr Tully Rosen, TAMHSS, Mental Health Policy Consultant,
Dr Paul Fanning, former LHD Chief Executive, Area Director of Mental Health, and Associate Professor, University of Newcastle.
There was also input from another former Mental Health Commissioner, other academics and former mental health services managers. The group includes a range of disciplines and lived experience.

For Correspondence, contact A/Prof Roger Gurr, or via Ms Vivienne Miller, TAMHSS Secretary.

Introduction and Summary

We have been concerned about the lack of consensus on the definition of efficiency in mental health services and we have proposed a working definition. We have specifically commented on funding and payment systems, as you get exactly what you pay for, so the payments need to incentivise quality and best practice recovery, with minimum waste.

We have also specifically addressed:

- Integrated Care & Unitary Regional Strategic Plan
- Efficiency & Real-world Outcomes
- Payment Systems: poor evidence for, and lack of equity on regional & population basis
- Regional Commissioning Authorities
- Headspace primary care model (Recommendation 5.3)
- Developmental trauma
- Structural reform (Recommendations 23.1, 23.3 and 24.2)
- National Mental Health Commission (Recommendations 24.4, 25.4)
- National Mental Health Service Planning Framework
- Essential Components of Care compendium & tool
- National Role Delineation Guide for mental health services
- Rural, Remote, Telehealth and e-Mental Health
- Indigenous issues – Information requests 11.1 and 21.2
- National Accountability for Quality

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- Assertive Community Treatment teams in conjunction with the NDIS
- Workforce Development (recommendation 11.1 and 11.4)

Efficiency Definition

The most relevant definition of efficiency for mental health services has to be that a defined outcome is achieved with the least waste. What is assumed in any dictionary definition is that you start by knowing the outcome to be achieved. In mental health services the expected outcomes are generally not defined or are about activity that bears no real relationship with functional or consumer recovery goals, apart from whether you are in or out of hospital.

There are several problems in applying this definition to mental health services. Recovery and maximal social functioning are generally agreed to be the desirable outcomes, but the very wide range of disorders due to genetic and epigenetic factors (developmental trauma, life events, infections etc), ongoing interactions with physical health, behavioural reactions to current stress and social determinants of health, means that many models of care and desired outcomes have to be defined for a specific segment.

However, this can be done by designing models of care for each segment, both in terms of functional and satisfaction outcomes agreed by consumers, carers and the community, and delivery process outcomes in terms of benchmarking activity levels and adherence to fidelity tools. An example is the Early Psychosis Prevention & Intervention Centre model designed by Orygen Youth Health for first episode psychosis in the youth age group (12-25), with 16 components of care, implementation manuals and a fidelity tool with inspections. This can be considered best practice and other programs should be benchmarked against it. However, even it would benefit from better definition of desired recovery outcomes, and for this reason the current services are experimenting with tools such as the Recovery Star, which repeatedly rates 10 domains of life in full collaboration with the young person. The existing required measure, the HoNOS is clinician rated only and not designed as an outcome measure but as a clinical status measure, based largely on current symptoms, which can be highly variable in the short-term, so does not provide robust outcome trends, and is not considered adequate by consumers and many clinicians. An evidence based functional outcome tool is essential to determine ongoing trends in outcomes. The Life Skills Profile, designed in Australia, with worldwide applications, can be rated by clinicians, support workers or family carers, and provides a robust and reliable measure of ongoing functional ability and impairment, and is used as an outcome measure for both clinical and functional rehabilitation services (including public, some NGO and now also NDIS mental health services). It also could be synergised with a measure such as the Recovery Star, which is self rated (against written prompts) and fully collaborative, but also has a clinician observation rating.

Experience shows that to provide a clear model of care requires a) a strong evidence base for cost-effectiveness of suites of skilled interventions, b) intense education (not adequately provided by University courses), c) on the job skills based training (e.g. Orygen supplied manuals and 20 two hour

online interactive modules) and d) onsite maintenance via fidelity criteria monitoring and clinical supervision (to prevent reversion to previously learnt attitudes and behaviours, and manage endless staff turnover).

The major criticisms of current outcome measures are that they are mostly based on occasion of service activities or time limited episodes of care, as defined for activity based funding, which rely on very erroneous assumptions:

1. State services are providing adequate quality care, whether inpatient or community based. The National Mental Health Service Planning Framework (NMHSPF) shows that all jurisdiction fall short in providing sufficient inpatient and community based beds for those that need supervised care, let alone sufficient community based services, no matter the funder or provider (e.g. WA Mental Health Commission Plan in a state with the highest per capita expenditure).

2. The only outcome that matters is a reduction in service use and cost. Relentless population growth means that even CPI increases are not sufficient to keep pace. Mental health services need to cover the whole of life and there are clear phases of development of mental health disorders, as used by the NMHSPF. In economic terms, expenditure in those phases need to be considered appropriate to the desired outcomes. In children, youth (12-25) and adulthood before retirement, the effects of interventions should be considered as investments, as the many significant studies show not only reductions in personal, family and social pain, but also great returns on investment. The returns are increased tax collections and reduced use of treatment and support services across the spectrum, particularly in preventing chronic physical health conditions. It used to be said that 80% of health expenditure is in the last two years of life, and that could be seen as dead money rather than investment in children and youth.

3. Medical treatment services in mental health can be seen, funded and evaluated in isolation from the social needs and determinants of health.

Real World Outcomes

If we are going to be honest in assessing efficiency, we need to look at the real world drivers of decision making by systems and clinicians, that result in hidden outcomes, as mental health patients are often ignorant about what they should be receiving, or not able to articulate and complain about poor outcomes. What can seem to be efficient, can be hiding ongoing dysfunction and quiet mental illness in the community. The following behaviours have been observed and not controlled by current methods:

1. State public sector provider real outcomes seen: – do not come wanting an admission, as we cannot cope with the demand from people we are obliged to admit, do not create a public

nuisance, if in need, bother someone else! Keep LHN funding pooled so that diversion to general medicine/surgery can be hidden.

2. Private fee-for-service provider desired outcomes: – attend on time, take medication/psychotherapy, hoping that you guess as to the right medication/ psychotherapy (a problem with DSM5 diagnostic categories) and that it works at least partially. The treatments, while usually having statistically significant value in large controlled trials, still usually have low effect sizes compared to placebos, due to the high levels of confounding factors, the lack of specificity in DSM5 diagnoses, and comorbidities. Often 40-45% of people in a trial of medication or psychotherapy do not get better during the trial. Many people do not achieve desired outcomes, but fees will still be paid from tax-payers funds – an obvious waste.

3. Private hospitals often admit people who could be managed at home, and they may stay until their insurance limit is reached. The more severe end of the spectrum are then referred to the Local Health Networks (LHN) for admission or community follow-up, without responsibility.

4. Non-Government Organisation (NGO) community based services – get the next contract. The current contracts have variable levels and models of care and outcomes defined, but usually outcomes are more activity based than measurable health/life benefit outcomes. The problem of market competition is a tendency to contract with the lowest bid, rather than evidence that the quality outcomes are actually likely to be achieved. It is difficult for NGOs to achieve quality due to fragmentation with many discrete contracts and variable lengths of contracts, considerably lower rates of pay in national awards, damaging to recruitment and retention of quality staff. This adds to real costs through continuously needing to run orientation, education, training and supervision programs. Reducing these costs leads to reduced quality from inexperienced and poorly trained staff.

The right outcomes will not occur unless the incentives change, through better model of care designs, fidelity tools, outcome measures and payment systems. How good is current efficiency?

Payment Systems

We are concerned by the lack of evidence on the benefits of different payment systems. There are pros and cons, and in our view the system should provide incentives to achieve the recovery outcomes desired by consumers and carers, as they are also the outcomes that lead to more productive, meaningful lives and less burden on the state. That is efficiency in mental health services. Below is commentary on the current payment systems.

Fee For Service

There is little evidence that private services are generally providing efficient care, or adequate quality of care, whether inpatient or community based. Fee for service rewards, seeing people for as long as the money lasts, whether or not the desired outcome is achieved.
Medicare fee for service rebates fail to achieve efficiency for several reasons:

- Failure to ensure the equitable distribution of providers. When we were able to get Medicare data under FOI, analysis showed that the highest per capita rebates in NSW went the wealthiest areas (was Malcom Turnbull's electorate) and the least to the Mt Druitt electorate, where there is high public housing and need. Thus any pooling of funds and cashing ought to correct these imbalances, not perpetuate them, and provide at least the per head of population average (see section on integrated care pooling).
- Failure to provide an equitable access to the providers that are available, due to varying ability to pay the gap. The freezing of Medicare rebates, or the less than CPI increases over many years, have made bulk billing progressively less attractive.
- Failure to contain costs to the taxpayer (uncapped budget – diminishing resources available to more targeted investments) and to the consumer (providers find the gap they can get away with charging and just increase their fees by the amount the rebate is increased – e.g. when psychologists gained access to Medicare.
- Based on historical charging behaviours with no relationship to the value of the service provided.
- Based on the historical model of individual clinicians in an office behind closed doors, when there is ample evidence that quality mental health care is team based and changes to Medicare items trying to improve this are not effective.
- Failure to achieve quality – The US Institute of Medicine major study on "Improving the Quality of Health Care for Mental Health and Substance-Use Conditions" basically concluded that it was not possible to ensure quality with fee for service systems without clear models of care and supervision.
- Fee for service payment systems ignore demographic and ecological differences. Data in Blacktown in the 1990s showed that the rate of psychiatric admissions to the local public inpatient unit went from 250 in 1992 to over 900 by 1999, due to the manufacture of amphetamines and delivery by the Bikie gangs, and the growing of cannabis by people copying market gardeners, who also grew lettuces by hydroponics. The data showed that if you had a public housing address, you had twice the chance of an admission. High concentrations of indigenous, refugees and other non-English speaking people create increased need and required adapted models of care in Western Sydney. Clearly regional, rural and remote areas also require customised funding ratios and delivery vehicles, as the population does not have the money for out of pocket costs and clinicians do not like the clients, preferring to see people of their own class.
- Fee for service payment systems currently only apply to specific disciplines and the payments are not fair for the value of the inputs (psychologist versus occupational therapist, exercise physiologists etc) and the important addition of workers with lived experience – peer workers. If we are to remain with fee for service payments, they need to be radically overhauled for effectiveness and efficiency

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Demonstrated effectiveness of services to achieve desired outcomes is the priority, before assessment of efficiency through reducing waste. We are still waiting for evidence that fee-for-service payments to clinicians provides efficiency.

Activity Based Funding

As recorded in the draft report, there are real problems with the use of activity based funding for community based mental health services. While two of our group have been involved in the previous and current IHPA attempt to develop a workable model, as we have observed the process, it has become clear that for mental health, the whole premise is wrong. ABF may work in hospital settings where there is a single disorder in focus, such as a myocardial infarction or an appendicitis needing surgery, where the treatment is well defined and there is low variability in outcomes, compared to mental health, where the diagnosis is a minor component of variance and a wide range of interventions are required, whether clinical, psychosocial, relational, and/or attending to neglected physical health care, beyond the narrow direct health intervention of medication etc.

Once a package is defined, say by phase of care, and the classes defined, the current services are costed against those classes and the average computed and weighted to provide a price. There is no consensus even within the IHPA Mental Health advisory networks, as to the definition or description of these phases, as deliberations continue as to whether ABF for episodes and phases should pertain to traditional episodes or phases of care, e.g. prolonged in-patient or maintenance care, and whether they should encourage contemporary evidence based good practice: that is whether there should be incentives to provide less life disruptive and more cost effective contemporary, recovery oriented, proxies for these phases in the community. But in this process, the outliers are trimmed – e.g. Queensland provides more occasions of service per person, so they will not be funded for those extra occasions, whereas an evidenced model of care would support them. If the prices are determined based on costing average state services that operate with no evidence based model of care, with well known significant underfunding and with very limited recovery services (even if only compared to the NMHSPF), then the process just cements into place poor quality outcomes. It could mean that the Western Australian attempt to fund on a rational basis would be undermined.

Our concerns remain, though pursued since 2012, that ABF is too explicitly hospital centred in its identity (e.g. IHPA only specifies hospital related pricing), and the list of community proxies that it now proposes to price and fund, (following strong advocacy) of community services which are likely to be employed instead of hospital care, is very limited and incomplete. See: Rosen A, McGorry P, Hill, H, Rosenberg S, The Independent Hospital Pricing Authority and mental health services: it is not a matter of "one size fits all". Medical Journal of Australia, 196 (11) 18 June 2012: 675-677.

If ABF was to be used, then the high diversity of needs actually requires a very diverse range of skills and interventions, so there would have to be hundreds of classes properly costed on best practice case projections. This can be overcome by commissioning defined models of care and benchmarking against fidelity, outcomes and activity, taking account of the local demographics and ecology, with

supervision by the Regional Commissioning Authority and overseen by the National Mental Health Commission.

ABF would only support efficiency if the prices pay for best practice inputs, so that the desired outcomes are achieved. The services able to demonstrate fidelity to the model of care and benchmarked outcomes, would then be rewarded with adequate funds to continue. Where is the waste if services are properly funded to achieve the desired outcomes?

Block Funding

There is a place for block funding, as there are processes that are not readily managed through fee for service activity. Once a model of care had been designed, there are issues of critical mass in providing the range of services that should be integrated in house rather than externally purchased. There is considerable variability of demand, such as the surge in acute disorders and suicidality, particularly in Spring and in acute disorders, somewhat in Autumn, leading to increased community demand, emergency department assessment demand and bed blockage, with overflowing unwell patients parked around general hospital wards (unsafe). Some services have a drop in demand at times of school holidays.

The issue of inefficiency, with a low proportion of time recorded for direct care, patient present or not present, is due to the fact that most block funded services are for patients who are ambivalent about receiving what they perceive as stigmatising services, are young or homeless people who avoid most health, mental health and welfare services as much as they can, or are under community/forensic treatment orders and are reluctant to attend appointments.

The data, for example, from one early psychosis service showed that despite assiduous attempts at engagement and a preparedness to see the patient anywhere in the community, there has been a 12% no-show rate and a 27% cancellation rate, but only achieved appointments and failed home visits are recorded in the national data collection. The model limits the case load to 20 per case manager (psychotherapist) and a case load weighting tool is used to balance workload, as working with the youth age group can be quite intense and demanding, with a need for a lot of time spent in case review meetings with the psychiatrists and multidisciplinary recovery team, and additional support from the Mobile Assessment and Treatment Team (extended hours 7 days). Evidence shows that over 80% with first episode psychosis have significant developmental trauma and so are vulnerable to substance use to try to reduce their high anxiety, and to feel better in spite of low self esteem and unhappiness/depression. Their brains are dysregulated and so they are disorganised, dysfunctional and often also physically unwell. They mostly do not fit private practice psychiatry or psychology, and they are beyond the skills of GPs. There is evidence this is also true across many mental illness diagnoses, where severity has a dose-wise correlation with developmental trauma.

Block funding is currently the only way that comprehensive recovery services can be provided, including peer and family peer workers and specific skills for engagement and socialisation (Individual Placement and Support model for completion of education and employment, art therapy, music, body

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work, and a wide range of group programs) particularly important in the key early intervention periods of child and youth. These staff need to be embedded as part of the clinical team for effectiveness.

Block funding will be the only way that innovation can flourish to address new solutions and so achieve better outcomes and thus efficiency. The British evidence on return of investment for early intervention in psychosis was 17.97 to 1 (Martin Knapp et al), and this will be improved with current plans to address the developmental trauma component. How good is that return on investment?

Hybrid Payments

We support the idea of experimenting with new funding and payment models (Recommendation 24.4). The key issue is to ensure that the service design properly includes all the components of an evidence based, or promising, model of care, to ensure quality and the desired outcomes for the target group. As best practice models of care services should also be the training sites for clinicians, rather than narrow hospital based experiences, education and training components need to be built in for both students and graduates. There is evidence that there should be ongoing supervision of all staff, via a range of methods, and multidisciplinary case review meetings for the required teamwork. These processes appear to be better funded by block funding at this time. However, despite the problems of engagement and attendance at appointments, there could be Medicare rebate payments to encourage engagement and attendance for any face to face sessions. There could also be incentive payments for proposing and achieving model and process improvements.
This could include process and outcome performance thresholds and targets as specified in service agreements and funding contracts, similar to those operated by the WA MH Commission.

We suggest this should be managed by the enhanced National Mental Health Commission, as a core part of its proposed statutory role.

Integrated Care (Proposals 10.1-10.4 and 24.1)

The section on Integrated Care in the draft report focuses mainly on improving consumer relevant information (10.1) access to services through on-line navigation programs (10.2) the development of multi-provider single care plan(10.3) and care-coordination (10.4). Chapter 10 also makes reference to provider collaboration mechanisms through MOUs. Again there are useful references to integrating and making funding more flexible (24.1). The proposal to rebuild funding and commissioning structures function through the establishment of RCAs supports the development of integrated mental health care at the highest functional level.

All of these proposals are strongly supported. However, while many reports and plans including the National Mental Health Standards (2010) have grappled with the problem of what services and consumer focused activities should be integrated, few have articulated how this could be done. Therefore, while excellent recommendations have been made at the micro/clinical and macro levels of the system, this needs to be an important component of the PC draft report. This should include in

an overall framework for understanding the scope of what integrated care should involve and initiatives based on the implementation science available for it to be effective.

The draft Report indicates that to achieve integrated care all stakeholders (including policy makers, funders, providers, consumers and careers) need to go beyond "good will" and suggests joint MOUs and co-location of services as ways of doing this. However the report is vague about how integration should be achieved across the system as a whole in terms of funding, planning and service delivery. There are references to the work of some PHNs, but little in terms of frameworks and formalised, shared systems of governance that could be used by RCAs, PHNs and providers alike to form comprehensive, integrated networks of mental healthcare.

Examples of this approach have been undertaken internationally and described in the literature. These include the "Collective Impact" framework developed by Standford University in the US and initiatives promoted by the International Foundation of Integrated Care (IFIC) through conferences, webinars and its International Journal for Integrated Care. Locally "Integrated Mental HealthCare Networks" of funders, providers (Public and NGO), consumers and carers have been established in the Central Coast PHN and the St Vincent's (Sydney) mental health catchment and reference is made in the PC report to the multi-agency collaboration in Melbourne (Eastern Mental Health Service Coordination Alliance – EMHSCA).

In terms of the draft Report, the recommendations for the Macro and Micro levels of the system are very good starting point. However, at the meso-level of the system, while co-located services and MOUs between organisations are supported, the implementation of provider driven, regional "Integrated Mental Health Networks" (IMHNs) initiatives involving the mapping of services (Romero-Lopez-Alberta 2019) and the utilisation of "Collective Impact" principles and strategies would, we believe, enhance service and consumer outcomes including the efficiency of existing systems of Mental Healthcare. For example, at the Meso level IMHNS would jointly develop Care Pathways, Shared Care processes, Quality Assurance Mechanisms, Clinical Governance and Quality Improvement Mechanisms, Education and Training, IT enhancements and Evaluation and Research initiatives.

There is a growing literature related to the development of integrated mental healthcare in Australia involving contributions from several research groups over the last 2 decades and involving authors such as Burrows (2007) Eagar (2005), Perkins (2014) Whiteford (2014) and others. Pointing to the benefits but also the challenges of integrating mental healthcare, the work in this field has been very "start-stop" in nature which may account in part for the lack of progress cited so frequently in national Mental Health reports including the draft PC report.

So what is needed to change the current and long standing trajectory?

1. In addition to what is already documented in Chapter 10 of the draft report, a clearer statement needs to be made in a Section on Implementation, that integration needs to be comprehensive and occur both vertically and horizontally involving micro, meso and macro levels in the system.

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2. The reasons for recommending this approach referenced to whole systems approaches and the contribution of implementation science to effective implementation, needs to be documented.

3. Thirdly local examples, mentioned above, should be referenced. The Central Coast summative evaluation is available on the Web.

4. Initiatives including those already referred to in the draft report could be written up in a table referring on the one hand to Macro, Meso and Micro level and on the other to Planner/Funders, Providers (Public, Private and NGO), Consumers and Carers and Joint initiatives.

Recommendations: Integrated Care:

1. **10.1-10.4 and 24.1 are supported**
2. **Mechanisms to integrate mental funding, planning and service-delivery, within and between macro, meso and micro levels of care should be implemented**
3. **With regard to meso-level, inter-organisation initiatives, integrated networks of provider-driven mental healthcare, should be established, funded and held accountable by RCAs.**
4. **Large system processes of efficiency analysis, such as those undertaken now, should be repeated to identify progress and opportunities for systems change where relevant.**
5. **A unitary /single MHS Regional Strategic Plan, including all public, NGO, fee-for-service or other private mental health, welfare or support services, to be commissioned and contracted by the RCA, will be co-designed by the RCA, in consultation with representatives of all stakeholder groups, and employed as a basis for RCA's to contract all components of a regional MHS.**

A program that worked in this direction was the National Mental Health Integration Program (Prof. Harvey Whiteford chaired the reference group) and the lessons included that involving private practitioners (including psychiatrists, psychologists and other allied health clinicians) and having the means to design payments to achieve integration goals, lead to shaping of behaviours that increased the quality of care. Thus any use of Medicare rebates should be progressively shaped to improve integration of interventions and support services, within team structures that provide easy ongoing communication, case reviewing, supervision and continuing education and training as the evidence evolves. In the major integration project in the Illawarra, the funding pool was made up of the average state and Commonwealth expenditure per head of population. Medicare claims were paid out of this pool and any left over funds could be used to purchase services that were geographically missing. The local private practitioners were happy and there was no political flack. The results were positive on every measure, but despite prior promises from both levels of government to continue the program if positive, it died from the loss of the champions in the two health departments. This project should be repeated with a wider series of project sites, urban, regional and rural/remote, under management and evaluation by the National Mental Health Commission.

Eagar K, Pirkis J, Owen A, Burgess P, Posner N, Perkins D (2005) Lessons from the National Mental Health Integration Program. Australian Health Review, Vol 29:2
Perkins DA, Roberts R, Sanders T, Rosen A, Sanders T, Roberts R et al. Far West Area Health Service mental health integration project: model for rural Australia? The Australian Journal of Rural Health 2006: Vol 14 , 3 pps. 105-10

Rural & Remote Mental Health Services

As many community mental health services have become depleted and partially dismantled they are being incrementally and surreptitiously replaced by essentially fee-for-service Medicare subsidized services with gap payments, private and corporatized telepsychiatry, telehealth, and e-health services. This is a form of tacit cost-shifting to the Commonwealth and the privatised gap payments. Many of these practitioners do not ever visit these regions and do not liaise intermittently with GPs, community mental health teams, families or others who will have to cope with the crises of the individuals they assess and treat.

Mild disorders may respond well to e-health websites, checklists, subjective ratings and therapies, especially with young people, people who are more comfortable seeking services via internet, and those who are shy or wary of personal engagement with service providers. Individuals with **Moderate** disorders may need "hybrid combinations" of in-person, telehealth and on-line mental health services (Yellowlees P & Shore JH, APA, 2018) while individuals and Families with Acute, **Severe and Complex** psychiatric disorders usually respond best to inclusive in-person engagement and interdisciplinary teamwork (eg. Hickie I, ABC-RN, 1 April 2019) with well coordinated and integrated division of labour, and high level ongoing team support.

Resources for public in-person community mental health services should not be compromised or sacrificed for telepsychiatry, other telehealth and e-health programs, which may ultimately increase case-finding and demand for in-person services. Some governments and mental health administrations may be tempted or persuaded to incrementally, or rapidly, replace in-person community mental health services mainly with telehealth services and e-health facilities. We need both, and a well-integrated and carefully monitored balance between them. It is probable that both components will require further government enhancements.

Recommendations:

A. **Troubled Individuals and families with mental health problems in remote regions should not have to just rely on telepsychiatry, other telehealth counselling and e-Health strategies, individual allied professional counselling, or support workers for help with mental health related issues for individuals, families and communities, sometimes without ever seeing them in person, and often in isolation from and uncoordinated with familiar local health and mental health professionals.**
B. **Community mental health teams in rural and remote regions need re-investment, restoring full team complements, providing upskilling and supervising of staff, pastoral mentoring and stabilisation, so they can work across their regions to a repertoire of proxies for evidence based interventions and service delivery systems.**

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e-Health Mental Health Interventions.

Automated digital services can provide a much larger scale of reach at the population level, and can be most effective as primary screening & secondary prevention strategies, and can be very effective as interventions alone, particularly for milder to moderate disorders. This may lower demand for in-person services for milder disorders by GP's, community mental health teams, and private psychiatric and psychology services. But it could also uncover latent population demand for in-person services for moderate to severe disorders, which cannot be met with existing workforces.

When individuals accessing e-health mental health hubs need escalation for higher severity and acuity, and/or perceived danger of harm, automated escalation is not sufficient nor always reliable or safe. Explicit protocols need to be systematically applied to ensure formal confirmation of acceptance of hand-over of duty of care, at an appropriate level of urgency. This needs to be assured and communicated both ways, verbally and with documentation, between identifiable service provider persons. Monitoring and management of this and of peak flows of demand for escalation are issues for integration mechanisms between services, including formal service agreements. Public mental health services, and particularly Community mental health staffing levels and mobility, should be reviewed to ensure that sustained increases in demands via these portals can be met.

Telepsychiatry and other Telehealth mental health services

Psychiatrists and other clinicians offering telehealth consultations and advice are best provided in combination and balance with intermittent in-person psychiatric consultations and reviews, optimally by the same psychiatrist or by the same rostered and collegiate group of psychiatrists, providing local team and GP consultation, and clinically hand over to each other. Such a combination should provide better engagement, greater accuracy of assessment and review, better appraisal of physical health needs, better communication and clinical supervision with local GPs and community mental health teams, and better peer review. While telepsychiatry and telehealth counselling are now becoming highly valued components of mental health services for rural and remote communities, it should be part of a mixed and balanced economy or well integrated spectrum of mental health services. It should not be offered as a stand-alone service, particularly in rural settings, without firm Commonwealth, Medicare and RANZCP requirements to act in close and regular clinical communication with GPs, community mental health teams, and families, especially if agreed by the initial service-user. It is often community mental health teams who have to deal with ensuing crises and acute admissions, sometimes by complete surprise, as telehealth practitioners are not required to do nor are they separately reimbursed for such regular communications.

Recommendation: Telepsychiatry:
Medicare subsidized doctor and psychology/allied health telepsychiatry and Telehealth Mental Health Services, where needed for the regional mix of clinical services, should be strictly contracted and regulated by Regional Commissioning Authorities. Under these provisions they should be obliged to:

a) **eliminate or severely limit gap co-payments,**
b) **liaise regularly with GP's and in rural & regional settings with community MH teams if risk of presentation to public services, and with families (with permission of the service-user if voluntary),**
c) **be governed by a single regional MHS plan integrating all public, NGO and any privately contracted MHS. This plan should have some formal obligation status such as strictly operated contracting, rather than just a loose in principle service agreement (see Integrated Care, recommendation 5).**

These arrangements should underlie regional pooling & commissioning and should replicate the WA MH Commission method of ensuring delivery of contracted services, whether with public, NGO, private institutional or fee-for-service sectors, with monitoring and auditing of both budgets and expenditure acquittals to ensure no shifting of resources to non-contracted or non-MHS services, or funding will be promptly withdrawn.

Headspace Model (Recommendation 5.3)

The primary care headspace centre model is excellent in being a safe place for youth to self present, but is flawed, as direct observation of several centres shows it relies on very junior clinicians to triage, diagnose and formulate, and then relies on altruistic psychologists to provide psychotherapy on bulk billing rebates (less facility fee) and a few other clinical disciplines. The young people walking through the doors have not been pre-selected as mild to moderately disordered (the program target) and so the whole spectrum of disorders and severity arrives. They often have significant developmental trauma and other disorders that are way beyond the competency of the staff, but they cannot find anywhere to refer them to (rejections from LHN services and private practitioners wary of the age group). There is not a skilled diagnostic and formulation component on site and attempts to include GPs and psychiatrists in the process have often failed. With the high no-show and cancellation rates, psychologists and GPs often do not stay for long, and so there is also very limited psychotherapy available, even for the targeted mild to moderate conditions, leading to long waiting lists. The funding is so tight (no regular inflation increments) that they often cannot cope with intake demand.

We do not believe **recommendation 5.3** is the full answer to the problem, as a major difficulty is effectively treating the more severe end of the spectrum and those that do not respond to online programs and/or medication. The centres really need more funding, with psychiatrists added on salary, or with guaranteed income if Medicare is charged, including funding to cover staff education, training, case reviews and holidays, if the market is to be met and staff recruited and retained, especially with the current uncertainties of contract employment. All staff need to receive pay and conditions equivalent to the state funded mental health services awards to retain the skilled staff required for good outcomes (huge staff turnover). Without the benefits of permanent employment, Psychiatrists mostly expect to be paid at Visiting Medical Officer rates, as occurs for contracted specialists on the LHNs in NSW. The centres cannot substitute for the lack of properly funded community based services needed (see NMHSPF) and especially for the recently recognised high prevalence of young people with significant developmental trauma looking for help. While online

treatment programs have a role for some and headspace staff could be better educated in how their young people could use them, in this youth age group most need one to one care and way more than 10 sessions (many documented and evaluated models of care). If there were properly funded stepped care services available for the moderate to severe, we are sure that appropriate referrals would be made.

Efficiency will come when the headspace centres are actually resourced properly to do the job in an integrated care system with all the referral components available.

Developmental and later Trauma

This is our greatest unsolved public health issue (US Centres for Disease Control)!

It needs specialist action, starting with the most severe and trickling down, rather than starting with the mild to moderate and expecting to learn how to deal with the most severe, personally painful (3/4 of achieved suicides), socially painful (e.g. almost everyone in custody) and expensive outcomes.

Due to failures of the treating professions and academics, assessing and treating trauma needs a commissioned investment in developing and evaluating the promising treatments. Incremental improvements are too slow – the costs of slow action are huge. It should get higher priority than cancer or cardiovascular disease, but there are no commercial drivers, as medication is not the answer, new treatment technology (qEEG recording, analysis and neurofeedback operant conditioning) requires extensive learning, and the treatments are time consuming (but can be permanent). But the prevalence is high – at least 17% have significant developmental trauma and the Dunedin cohort study showed rates of PTSD of 13.7% by the age of 38, and PTSD is only a subset of trauma responses. The effects of the brain dysregulation on physical health are as bad or worse than on mental health. Have the experience of 5 or more types of trauma and your life span is reduced by 20 years. It is much more prevalent and damaging than any other determinant of illness. We refer you to the attached paper on developmental trauma.

Once you see traumatised young people and know what can be done, but you cannot do it, is very painful for a caring clinician. Most clinicians prefer to ignore it, as they do not now what to do and just fit the person into a DSM 5 diagnostic category, which is confounded by not having taken account of developmental trauma in its formulation.

Developmental trauma needs to be addressed with age based cohorts – perinatal, early and later childhood, adolescence and youth, and the legacy in adults. We should be screening for it at all levels. The evidence is that clinicians do not ask, but the earlier you ask, the more you are told.

Recommendation: Developmental Trauma
We recommend that the Commission actually acknowledge the issues around developmental trauma and make a recommendation that significant resources be allocated to address it under the management of the National Mental Health Commission.

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Draft Recommendation 23.3 – Structural Reform is Necessary
Information Request 23.1

Ideally need to reform the constitution, but now have to address the effects of the fiscal imbalance (Twomey & Withers 2007), where the Commonwealth raises 82% of taxes and the states only 18%, while the states need at least 40% of tax revenue to provide the services intended under the constitution. This is the cause of the creeping intrusion into service provision by the Commonwealth, for short term political gain, rather than as part of an integrated and comprehensive service plan. In fact this advent has fragmented services further, as successive Commonwealth Governments have not trusted the states to provide these largely support (rather than clinical) services directly. The Commonwealth have wanted to retain control of the enhancements it is funding, probably for both party political purposes, and because the states have misdirected previous enhancements. It is the reason state health services need to find ways to cost shift to the Commonwealth. Both levels of government try to push the responsibility for rationing decisions to arms-length organisations (LHNs, PHNs) dressing it up as a local decision-making virtue. Here and internationally, mental health services have been vulnerable everywhere their funding has been pooled with physical health funding, unless there are very tight controls.

Historically State and Commonwealth mental health service funding decisions have been made in secrecy (the bane of our Westminster form of government and public service culture). The public service has poor levels of knowledge (Commonwealth public servants expected to rotate every couple of years to entirely different roles) and consultation processes are often superficial, so that poorly designed programs are announced and then not changeable because the Minister has announced them. Experienced managers responsible for actual implementation are rarely consulted.

The lack of clarity of roles and planning for integration has given us the missing middle, between highly constrained state services and the fee for service single practitioner market with all its distortions and perverse incentives. Only a structure with control of funding and payments will be able to progressively shape behaviours through trialling and evaluating new funding and payments methods. This needs a structure at arms length from the political pressures of vested interests. Pooling of state and federal funds could ameliorate conflicts over responsibilities, but there is still the problem of which government is accountable. Ideally the National Mental Health Commission would hold the national mental health funds and procure the mental health services up to and including the services provided by the LHNs as in Western Australia. Because of the need for whole of government responses to mental health consumer needs, well beyond medical care, the NMHC should report to Prime Minister and Cabinet, not the Commonwealth Department of Health. Budget bids need to go directly to the Treasury and Finance, and not get caught up in the competing bureaucratic silos.

Thus the structural reforms need to be integrated horizontally and vertically to get the best results, as discussed above. The National Mental Health Commission, as a statutory body, needs to be strengthened to provide expert leadership in collaboration with State Mental Health Commissions, Regional Commissioning Authorities and NGO planners, to provide advice to governments and

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guidance to Regional Commissioning Authorities. In order to have competent providers to tender for commissions, there needs to be involvement by them in co-design of local commissions, even if they then compete, as there is greater clarity of what is required, and reasonable performance expectations etc, in adapting the design principles for a specific model of care to the local ecology. This model has been successfully used in Victoria.

We support the view that the mental health (and substance use) commissioning needs a specialist organisation with a wider view than the current PHNs and with the critical mass to support more specialised and complex commissioning, including relevant social services. The size of the catchment area should be relevant to the needs of the region. For example, it has been important that the WA Mental Health Commission has covered the whole state at this phase of development, commissioning the LHNs as well as NGO providers in a very diverse ecology. There are real dilemmas in designing very specialist services (e.g. forensic) to achieve local access and also efficiency.

As you get exactly what you pay for, holding the whole budget provides real tools to ensure integration vertically and horizontally. There has been too much reliance on illusory "good will". Ideally the Regional Commissioning Authorities should have the pooled State and Commonwealth funds for mental health service and alcohol & other substance use funding to purchase from the LHNs as well as NGO and other providers, for the full suite of health and social services. RCA's for larger states and cities would need to be divided into regional commissioning entities.

We agree with the comment that the Commonwealth Department of Health should not be telling Regionally Commissioning Authorities what to do (**recommendation 24.2**) but that is because it is politically driven rather than based on expertise. We do believe that there needs to be good advice, and at times clear guidelines, based on the current evidence for the design of models of care, including specific interventions and service delivery vehicles, and adherence to fidelity. With the integrative processes of planning above, central dictatorship is much less likely to occur and there should be checks and balances built into the structural design to value the layers of contribution to commissioning outcomes. Good commissioning in mental health needs high level expertise, and 31 PHNs are unlikely to have that capacity.

Observers of New Zealand noted that their best period of commissioning was when the country was divided into 4 zones of about a million population, with the expert commissioning teams advised by the Mental Health Commission plan and connected to the health ministry. This gave the politicians the confidence to invest a lot more, so that their services became much better than those in Australia at that time.

The British experience has been similar, in that the best improvement came when there was a national planning framework with principles to be followed, including the evidence based models of care and delivery vehicles available at the time. The fact that the public sector providers were specialist Mental Health Foundation Trusts meant that funds were not diverted, but the commissioners, based with primary care trusts, required a lot of support to commission well.

Recommendation 24.2 should be amended to ensure that clear and evaluated models of care do not have their fidelity destroyed by local decision makers unaware of the consequences.

Some may criticise the proposed rebuild on the basis that it requires yet another bureaucracy, but with an integrative approach, it could bring together currently dispersed streams, occupying the time of scattered bureaucracies, so bringing the many streams together and including new streams of social services, would actually create greater efficiency through greater effectiveness, with no material increase in overall staffing costs. Giving the NMHC and state MH Commissions real involvement in planning and implementation, rather than being exercises in public relations, would be much more efficient. Considering the life-long value of effective mental health and substance use services, a critical mass of people to provide expert advice, support innovation and evaluation, and manage funding would be a great improvement on current methods. To continue as we have been, and to expect a different outcome, is more than just unwise.

Recommendation 23.3 should be amended as follows:

The Australian Government and State and Territory Governments should work together to reform the architectural framework of Australia's mental health system, to clarify federal and state roles in planning, funding and implementing integrated mental health care, so that governments can be incentivised to invest in services that best meet the needs of people with mental health illness and their carers. There should be a greater vertical and horizontal balance in planning and decision making, for the implementation of evidence-based models of care, as well as mandated integration, liaison and cooperation between commissioned services. The National Mental Health Service Planning Framework should be made publicly available to enable expert inputs for progressive improvements that will assist the reforms.

National Mental Health Commission (Recommendation 25.4 and 24.4)

While it would be difficult to get the NMHC to become the national mental health services fund holder in the short term, in the meantime, we support the upgrading of the NMHC to a statutory authority to include the capability to:

- Provide knowledge management – hire expertise, commission research, accumulate evidence for interventions and delivery vehicles, consult across the sector, propose new models of care to be piloted and evaluated and have sufficient discretionary funding to do these tasks directly.
- Work closely with state and territory mental health commissions and national and state government departments to receive their advice on issues relevant to that state or territory, and collaborate on planning with them. Mental health requires integrated whole of government programs to be optimal.
- Support planning processes and proposed national rolling plans for implementation, make proposals to government on priorities for investment.

- Advise Regional Commissioning Authorities on the models of care and commissioning principles to be followed, plus monitor and evaluate the commissioning practices to ensure fidelity and the commissioning of quality and financial integrity.
- Review and propose new funding and payment methods, to progressively overcome the deficiencies in the current arrangements.
- Collect and analyse data to enable the above.

What is missing from the current **recommendation 25.4** is the important inclusion of the need to provide knowledge management expertise and the power to make service proposals and to have the funds to commission research and pilot services for new or amended models of care, as there is no other mechanism to effectively do this. **Recommendation 24.4** should include the NMHC itself being able to propose pilot programs and then involve the relevant RCA in the process and contract management. The NMHC must also ensure that it has the expertise specifically in mental health services planning, commissioning, practical implementation and leadership of comprehensive community-based regional mental health services. Note that there is little expertise at present in the NMHC with these skills.

As part of accountability and auditing the NMHC should commission regular qualitative pathways studies--such as studies of the personal experiences of service users and families to ensure that they are not being excluded by inflexible eligibility criteria, experiencing unnecessary hurdles in accessing early, or ongoing services as required, or falling through the gaps between services.

Regional Commissioning Authorities

Pool as much funding as can be achieved from Commonwealth, State and ? insurance sources to cover mental health medical, psychological, recovery inputs and components of social supports. They should be able to purchase supports that the NDIS model is not able to effectively and locally provide, due to a lack of provider expertise and the critical mass to make a specialist service viable for potential providers in the marketplace. There are various at-risk minority and special population groups, such as co-occurring psychiatric and alcohol and other substance disorders, vulnerable youth, homeless people, prisoners, brain injury, eating disorders, LGBTIQ, indigenous, refugees, first responders etc, and their families, that could benefit from a more granular approach. For example, around 22% of the young people walking through the doors of primary care headspace sites present sexuality issues, but just when they need support to come to terms with their sexuality and to establish their place in society, the relevant organisations do not have the funding to help locally.

After the Richmond Report in NSW, the Dept of Health was given capital funding to "purchase" properties from the Dept of Housing, enabling them to build or purchase additional housing stock. In Blacktown we were flexibly able to obtain houses for group homes while vulnerable people waited for long term placements, and to swap houses if local problems arose. Pooled capital funding is also necessary, as essential facilities may not be available.

Thus the Regional Commissioning Authorities need to be able to commission towards the integration of services with the right skills and distribution for their demographics and ecology. Regional

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Commissioning Authorities also need to have a large enough catchment area for critical mass for the more specialist requirements.

National Mental Health Service Planning Framework (NMHSPF)

Should be made public and available for critiquing and improving, as it is 7 years old and the science has moved on. The product of the millions spent on it belongs to the taxpayers, not any secretive government afraid of revealing the service deficits. The Western Australian Mental Health Commission used it in its planning and published the results, with no political crisis. It is scandalous that the National Mental Health Commission has not been allowed access to it. Australia needs the best possible data for planning and this has been the best attempt so far. To set rational targets for improvement and equity of distribution of resources, the NMHSPF must be available to the NMHC to advise the Commonwealth Government, which controls 82% of the tax revenue. The state governments should welcome the truth about needs, to better negotiate with the Commonwealth Government with public support.

TAMHSS' Essential Components of Care [ECC] Tool for Regional Prioritizing of Evidence Based Interventions & Service Delivery Systems

ECC is a comprehensive tool for choosing priorities for wider implementation in particular regions, from among evidence based interventions and service delivery subsystems, which are of established cost effectiveness. It could be further developed by the National Mental Health Commission in co-design with all stakeholder groups and academics, and employed cooperatively to provide a menu and repertoire from which to choose priority services, which RCA's may decide to pilot further and/or bring to scale.

Recommendation:
Essential Components of Care (ECC) will be considered for implementation nationally, following alignment with National Mental Health Planning Framework, which can detail some important subsets of such services, and National MHS Mapping, which can pinpoint service duplications, overlaps and gaps. The ECC, as a national evidence-based planning tool, developed for Australian conditions, is potentially the keystone for assuring fidelity in practice and the skeleton to which resources can be attached, and with which service systems can be comprehensively audited.

National Role Delineation Guide for mental health services.

In NSW Health, the Role Delineation Guide for public health services is a core planning and evaluation tool for public health services, has recently been updated, and is used in various iterations around Australia. Clinical Service Planning (excluding Mental Health) at health service and hospital level is coordinated around this guide, but there is no equivalent for Mental Health. Despite our state mental health leadership recognising the need for something like this at the time, there was no support for inclusion of Mental Health within the Ministry when it was developed.

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Recommendation:
The Productivity Commission could recommend, or task a group, to develop such a Role Delineation Guide for mental health services for consistent national use, to support planning, service development and multiple standardized forms of evaluation and comparison. Comprehensive evidence based tools and models such as the ECC could be a core component of such a nationally applied Role Delineation Guide for mental health services.

Indigenous Mental Health Provisions.

PD Information Request 11.1

The Productivity Commission is seeking information from participants on any barriers impeding career progression for Aboriginal and Torres Strait Islander health workers, including barriers to the ability to move to broader health professions, such as mental health nursing.

The PD should recommend appropriate cultural provisions for members of Aboriginal & Torres Strait Islander communities with mental health and co-occurring clinical problems,

a) This includes ensuring culturally safe and appropriate mental health service provision for those who live outside Aboriginal communities e.g. in public or private housing, those who have been caught up in prolonged droughts and bushfire emergencies, whether as victims, threatened residents, volunteers or responders.

b) More Aboriginal Elders, Traditional healers and Aboriginal Mental Health workers should be employed in mental health services, and involved in co-design of culturally appropriate services, in service planning and everyday service delivery. Elders should be paired with senior managers to provide cultural consultation (M. Wright, Telethon Institute of Child Health Research, Perth, and Murdoch University, Fremantle, Western Australia).

PD Information Request 21.2: Does Empowerment lower suicide rates?

The Council of Australian Governments Health Council should develop a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and associated Implementation Plan to guide suicide prevention activities in Indigenous communities.

c) Ensure, for better outcomes, that Aboriginal MH Professionals are appointed to both specialty mental health teams and in primary health teams run by AMS Aboriginal controlled programs, but also need Aboriginal people involved on staff and on boards running other agencies, including police, corrections, family & housing services, fire & ambulance etc.
Evidence e.g. Chandler & Lalonde 2013, British Columbia
Expert/Authorities: Prof Pat Dudgeon, Director of the Univ West Australia Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP), Dept

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Indigenous Studies, UWA, W A.
A/Prof Christopher Lalonde, University of Victoria, British Columbia , Canada.

d) Ensure training, supervision and mentoring and pastoral care of Aboriginal Mental Health Workers (AMHW). The most prominent sound practice model is the Djirruwang Program, Charles Sturt University, Wagga Wagga, which has been the only University degree program to qualify Aboriginal mental health worker (AMHW) professionals in Australia. It had been envisaged that Edith Cowan University in WA would be the 2nd hub location for this course in the future. Restore the AMHW Mentorship Program which in NSW was successfully run for 10 years by Western NSW LHD and Far West LHD MHS, but was then defunded despite a 5 year evaluation demonstrating its effectiveness. Mentorship was shown to contribute to course retention and completion at degree level. **Authorities**: Dr. Faye McMillan Associate Professor - Director – Djirruwang Program/Clinical Coordinator, Mr Tom Brideson, NSW Aboriginal MHS Coordinator, NSW MH Commission Deputy Commissioner, Chair National Mental Health Leadership Group, Professors Alan Rosen & Maree Teesson.

e) Ensure provision for uninterrupted ventilation, personal narratives and story- telling, rather than rapid-fire clinical questioning as a means of assessment, clinical reviews and trauma debriefing. **Authority**: Prof Helen Milroy, UWA, Commissioner, Royal Commission on Institutional Child Abuse.

f) Routinely involve either Aboriginal Traditional Healer or Aboriginal Mental Health Worker in determining safe alternative placements to involuntary orders, before resorting to an involuntary order with Aboriginal people in crisis or emergency presentation. **Precedent:** as per provisions in the WA Mental Health Act.

g) Implement "Two Ways" or "Two Worlds" of living, and Gayaa Duwii Declaration on Aboriginal Mental Health. Authorities: Mason Durie, NZ, Charles Perkins (dec'd) & Tom Brideson, NSW (above).

h) Implement Language Revival as factor contributing to reducing and/or ameliorating mental illness and suicide In Aboriginal communities-under investigation with Barngarla People, South Australia, Brown A, Zuckerman G et al 2018-23. If successful, this initiative should be brought to scale with other Aboriginal peoples.

i) Response to 2019-20 Bushfire Season and Thereafter: As mental health conditions, anxiety and depression, psychological trauma, drug and alcohol dependency, family and communal violence and suicidal vulnerability can be precipitated or exacerbated by the stress of extreme environmental adversity, more investment must be made in ameliorating these, not just for farmers, town business people and their families, but for all those affected, especially the most vulnerable sections of communities, and specifically Aboriginal peoples. This should include particularly providing more essential community services controlled by Aboriginal community members themselves, with additional Aboriginal mental health workers, healers,

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mental health educators, peer workers and Aboriginal liaison officers, working alongside other mental health, health and social service professionals. Aboriginal people need stable local employment opportunities in their communities. From now on, we should take up nationally a huge opportunity to further develop traditional fire management alongside western science, creating and consolidating more valued jobs and respected land management roles for Aboriginal rangers, vital for the future of both Aboriginal and wider communities.

j) Aboriginal communities also need a more preventive, whole-of-life approach to social determinants, lifestyle factors, trauma and political decisions associated with compromised neurodevelopment, and increased subsequent incidence and severity of mental illnesses in their communities.
Reference:: Gynther B, Charlson F, Obrecht, K, Waller M, Santomauro D, Whiteford H, Hunter E, The Epidemiology of Psychosis in Indigenous Populations in Cape York and the Torres Strait, EClinical Medicine, The Lancet, 2019, https://doi.org/10.1016/j.eclinm.2019.04.009

National Accountability for the Quality of Mental Health Services.

Reference: Rosenberg S & Salvador-Carulla L. The Journal of Mental Health Policy and Economics, 20, 29-45 (2017) Accountability for Mental Health: The Australian Experience.

Our appraisal is based on some additions and amendments to the framework of this paper, which provides a timely call to all Australian governments, especially the Commonwealth Government, to take responsibility for assuring:

a) consistent comparative measurement of key performance indicators,
b) the choosing priorities from a menu of the most proven and promising evidence based interventions and service delivery systems to bring to scale [see Essential Components of Care document attached].
c) reconcile real mental health budgets, real mental health expenditure or acquittal and real accountability for them, on a consistent and comparative basis nationally.

Their initial conclusions detail several accountability subsets, which we have amended slightly and we have provided our specific recommendations.

(i) **Financial accountability:** Does the system operate efficiently?
This must also include comparative national auditing of jurisdictional nominal budget & acquittal, real per-capita spend, real proportion of health budget spent on mental health, real community compared with hospital based spend (we should count hospital outpatients as hospital rather than as community spend, as currently done) and acute vs rehabilitation spend for both hospital & community].

Recommendation:
A national annual audit of actual expenditure/acquittals by all jurisdictions of resources on mental health services. Provide Commonwealth incentives to the jurisdictions to stop cost-shifting to the

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Commonwealth and to the NGO's; to stop siphoning LHD mental health budgets to make up for overspends in medical and surgical procedures; and to reverse the favouring of hospital over community expenditure on mental health services. In terms of parity, calculate expenditures on mental health as proportion of all health expenditures, compare with other high income countries and raise towards 14% proportion of disability burden due to mental illnesses.

(ii) **Service Quality accountability:** Does the system meet quality standards of access, mobility and timeliness, etc? Are there effective processes of quality improvement?

Recommendation:
Update National Mental Health standards and link them to appraisal & rating systems for whether they are adhering to fidelity criteria for evidence based service delivery subsystems.

[Our group includes 2 co-authors of the National Mental Health Service Standards 1st and 2nd versions, which are way overdue for updating for facility LHD, PHN, private or NGO facility accreditation purposes and streamlining to make them more concise and relevant to an evolving environment including LHD's, NDIS, PHN's, e-health and digital gateways as well as engagement in evidence based educational, vocational and relational interventions].

(iii) **Outcome accountability:** Do consumers and carers say that the system meets their needs? Does this service +/or its partners apply expertise gleaned from diverse non-evidence based consultants and inexpert sources, or rather from the evolving international evidence base of both clinical and functional outcomes, and service-user recovery orientation and satisfaction research?

Recommendation:
To ensure completion and validity of ratings, these outcome measurement tools should be routinely used in negotiating individual care and recovery plans with service-users, and in regular clinical and functional reviews. The key outcome variables should not be symptomatic, but levels of functioning and recovery, measured both at arms length and subjectively, in working towards restoring "a contributing life" and full citizenship in the community. The latter should be employed to determine the most cost–effective and congenial service delivery systems and interventions to all at appropriate level of care.

(iv) **Policy accountability**: Does the system meet stated policy objectives, for example in relation to equity, parity and special populations, including those with co-occurring disorders, Aboriginal, transcultural, rural and remote, gender diverse and forensic communities?
We agree with the Accountability article authors' final conclusion: "The Commonwealth Government needs to provide the critical national leadership to drive the development of this new discipline.... This is not a job for individual jurisdictions."

Assertive Community Treatment [ACT] teams need to be restored nationally with co-located NDIS funded Support teams

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ACT teams are required for individuals who qualify for the highest tiers of NDIS Mental Health packages as a more humane alternative to lifelong hospital tenure or revolving door admissions. The clinical component should be funded by the jurisdictions, but many have genericized such teams in the illusory quest to save money. In fact, when dismantled, the pressure on ED and hospital beds rise enormously for these sub-populations. The model was designed as 50% clinicians and 50% support workers so they also need a co-located support team component which could be provided by the NDIS. This may well need block funding by the NDIA, but can be made completely compatible with existing personal packages.

Recommendation:
The Commonwealth should provide clear financial signals, via offers to the jurisdictions of partnerships and cost-sharing arrangements that they can't refuse, sending the strong message that the Commonwealth want them to provide non-sedentary active-response, home-delivery mental health teams with established evidence of better outcomes. These will demonstrate that personalised packages and some block-funded services are compatible, and that a balance between them should be sought, e.g. in the NDIS. [Such a proposal, matching jurisdictionally funded Assertive Community Treatment [ACT] teams with co-located support teams funded by the NDIS, has been considered by the NDIA, for 5 years now, but has not yet led to the foreshadowed processes of modelling and piloting by the NDIA, though pilot sites have been identified and are amenable].
A detailed proposal with costings for this initiative is available from Professors Alan Rosen, AO, Brain & Mind Centre, at University of Sydney and A/Prof Roger Gurr, School of Medicine, Western Sydney University.

Workforce Development & Sustainability:

The PC report is inconsistent in its description of the allied health workforce.
In section 5.3 it notes that psychological therapy can be delivered by psychologists, social workers and occupational therapists in private practice and that this could also be delivered by allied health professionals under the current PHN programs.
Many psychologists have raised their gap fees to clients well above the Better Access payment, whereas in general the other professions have not, thus making social workers, occupational therapists and nurses more affordable.
Later in the report the skills of social workers and occupational therapists are described minimally. Allied health professions include social workers, occupational therapists and psychologists (clinical or not), and each discipline is of equal value. Each has skills in psychological therapies as well as their own speciality skills. The definitions of occupational therapists and social workers need better defining, preferably by each of the professions themselves. For instance, occupational therapists have capabilities to assist people across a wide spectrum of their lives e.g. their physical, emotional, social health. Hence occupational therapists are experts, for example, in helping a person with complex trauma. They are able to assess and treat the person physical, emotional and social needs.

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*"**Allied health professions** are university qualified practitioners with specialist expertise related to physical or mental health. They include psychologists and the following professions.*

***Occupational therapists** assist people with daily living and work skills.*

***Social workers** help people deal with personal and social issues through counselling and community engagement."*

The report notes that "some consumers do not establish the necessary therapeutic rapport with the psychological therapist to which they are referred, and then drop out". The recommendation is for the consumer to have more choice of therapist. Does choice mean simply choosing another different psychologist, in which case it may be more of the same. The choice offered should include other allied health therapists such as social workers and occupational therapists with specialty skills not offered by psychologists.

When considering raising the number of Better Access sessions that are rebatable, the report suggests that: "those consumers identified as likely to require the additional sessions be referred to clinical psychologists (Littlefield 2017)". Where is the evidence that clinical psychologist's client outcomes are better than social workers or occupational therapists? In fact the more practical therapeutic approach of occupational therapists may lead to better outcomes for many clients.

We wholeheartedly agree with the recommendation:
"Strengthening the peer workforce through a more comprehensive system of training, work standards, an organisation to represent this workforce, and a program to build support for the value of peer workers among other health professions". The mental health field needs to have the voices of consumers heard. A peer worker has walked down the same path as the person needing mental health care and can be a guide, a companion, a support and an advocate for that person.

Recommendation:
A Federally funded Australian National Institute of Mental Health & Alcohol & Other Drugs [ANIMH+AOD] encompassing a National Mental Health Implementation Research Institute and Workforce Resource Centre should be implemented in parallel development in each jurisdiction with national coordination and curriculum development. It should then provide standardized evidence-based training materials and skills mental health and AOD enhancement courses for first responders of all kinds, including all clinical professionals, support workers, transcultural, indigenous and mental health workers, whether in public, fee-for-service, private or NGO sectors for all age groups, complementing the existing National Workforce Centre for Child Mental Health (www.emergingminds.com.au) ANIMH+AOD should then provide nationally consistent professionals & support workforce categories, training curricula, courses and qualifications in each workforce category, including peer workers. Also ANIMH would provide a nationally consistent supervision, mentorship and pastoral care framework. A detailed proposal with costings for this initiative is available from Professors Maree Teesson, AC, Matilda Centre, & Alan Rosen, AO, Brain & Mind Centre, at University of Sydney. (see also separate submission to Productivity Commission Inquiry).

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RANSFORMING AUSTRALIA'S MENTAL HEALTH SERVICES INCORPORATED

TAMHSS

TAMHSS Network recognises the cultural diversity of the many Australian communities, and the importance of engaging them in awareness of their own mental health and prevention and

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early intervention of mental illness, related stigma and discrimination. We also recognise the many special needs for services to deal with complex disorders.

THE OBJECTIVES OF THE TRANSFORMING AUSTRALIAN MENTAL HEALTH SERVICE SYSTEMS (TAMHSS) NETWORK ARE TO:

1. Provide a means for the Australian Community to become involved in the transformation of our mental health service systems.
2. Promote the rights of all consumers and families to receive services they need.
3. Promote a wide and consistent range of high quality mental health services across all age groups and throughout the country.
4. Promote interventions which are based on best practice as determined by both quantitative and qualitative evidence.
5. Promote a service delivery system that is integrated at every level including participation of all service sectors (public, private & NGO).
6. Promote the right of equity of access to all.
7. Promote a regional funding system and methodologies that provide adequate quality, control of both budget and expenditure, and transparent accountably, all of which should be independently monitored.
8. Promote recovery-oriented service systems which focus on the goals of social inclusion and citizenship.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AR-5

This is the attachment marked "AR-5" referred to in the witness statement of Alan Rosen dated 23 July 2020.

The NSW Government Special Commission of Inquiry into the Drug 'Ice'

Recommendations to the NSW Special Commission of Inquiry into the Drug ICE.
Far West NSW LHD MHS Consultation, July 2019.

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1. **Emergency Dept Presentations.**
   1.1 There should be a **senior mental health/D&A clinician** on the Emergency Department staffing roster with **Mental Health & Drug & Alcohol (D&A) expertise** on most shifts in the Emergency Department, particularly busy afternoon and evening shifts.
   1.2 There needs to be **a tidal on-call mental health & D&A professional roster** system based in Broken Hill to complement MHEC telehealth interactive video assessments based in Orange.
   1.3 At present, MHEC cannot interview behaviourally disturbed mental health and/or D&A affected presentations if they cannot sit quietly in front of the fixed camera in a house-doctor room adjacent to the emergency Dept. MHEC needs to install more safe and portable technology for interviews.
   1.4 Psychiatrists need to be more reliably rostered in-person in Broken Hill on a 7 day per week basis to be available to complete acute mental health assessments.

2. There should be real budgetary and acquittal enhancements to ensure a reversal in the erosive continuing reduction of senior clinical staff in the FW LHD combined mental health and D&A service, with **greater continuity of supervisory and role modelling** by seasoned, expert, competent and confidant clinicians, to ensure safety and a high quality of care, and to assist the recently graduated and trainee clinicians to develop.

3. We encourage the development of Mental Health & Drug & Alcohol capacity building educational CNC's to serve both Emergency Department and other Hospital wards and units. The expertise to be provided via the **Hospital D&A Consultation & Liaison Model**, NSW Ministry of Health, 2015, should be extended to community mental health team, primary health team, Aboriginal health & RFDS support.

4. There should be a sub-acute zone within the Emergency Department with the **equivalent of a PECC Unit** for individuals with violent or highly disruptive behavioural disturbance, who need to detoxify, or where it is

unclear what the presentation is due to, whether due to functional psychosis, substances abuse, or physical disorders eg acute metabolic or brain lesions. They should be able to stay in a small Psychiatric and Drug and Alcohol Emergency facility or pod, following the use of the High Dependency/ "Safe" Room for immediate assessment, that already exists in the Emergency Department , to free it up for the next violent or behaviourally disturbed presentation. Such a sub-acute unit attached to Emergency Department should be small in scale, eg maximum of two bedrooms with en-suites, with outside courtyard, and enough room in both to move about freely.

5. As cooping up behaviourally disturbed individuals breeds violence, the diminuitive **FW LHD Mental Health Inpatient Psychiatric Unit (MHIPU) needs to be relocated and rebuilt with adequate security and sightlines, and much more interior and exterior space,** as it will be needed for increasing numbers of individuals with acuity of co-morbidity of mental illness plus intoxication/dependence.

6. Far West Local Health District has sufficient polysubstance abuse and severe drug dependency to warrant a **Drug & Alcohol Detoxification & Rehabilitation Unit** to serve the Far West Local Health District and based in Broken Hill. Currently the closest facility is hundreds of kms away near Wentworth or Mildura. The lack of an accessible drug detoxification & rehabilitation facility in the largest centre for the entire western third of NSW with capacity to create vacancies promptly is plainly discriminatory to its population.

7. **Supervised Social Housing** or hostels or a HASI equivalent for D&A adaptation with support workers, including peers, should be provided for flow-through and follow-up after graduating from the detoxification and D&A rehabilitation facility.

8. Complementary services like **Child Protection, Domestic Violence and Housing, Aboriginal Health, RFDS, and Corrections Health & Probation/Parole services** should be upgraded to cope with individuals and families that have accumulated risk and harm over time because of ICE and other severe drug habits and their behavioural consequences. dealing with homelessness and interminable queues for social housing associated with comorbidity and drug misuse and dependency.

9. The proposal (attached) to form a NSW state-wide hub of an **Australian National Institute of Mental, Health and co-occurring disorders [ANIMH]** should be supported to provide consistent training, upskiling, qualifications, expert supervision and mentoring in the evidence based components of preventing and treating comorbid mental illness and AOD with special reference to ICE. This initiative has been led by Professor Maree Teesson, AC, and Professor Alan Rosen, AO.and relates directly to Matilda Institute submission to the ICE inquiry recommendations 2-4, with adaptations for Rural Remote contexts aligned with Matilda Institute recommendation 5.

10. The **professional culture of drug & alcohol counselling and support service provision in Australia needs transforming.** It is currently mostly sedentary, with providers delivering counselling in clinics or offices, mainly on a 1- to-1 basis. Rather, they need to be competent and confident at working in actual communities on the ground, home visiting whenever appropriate, with crisis, family and resource network intervention. Some of these drug & alcohol counselling organisations have re-colonised defunct, archaic and stigmatised former institutional sites, and are in danger of repeating psychiatry's past mistakes. We need the staff to be much more skilled in working with families of service-users, as there may be other drug-abusers in the family whom may pose obstacles to behavioural change of the present service-users, to help sustain their families in supporting and re-orienting the drug abusers in their extended kinship network, and to provide education, support, hope and encouragement for families who are trying to stand by their abusing members to help them change constructively. Eg current 3 year training of a sub-team of the St Vincents D&A service in "Open Dialogue", which potentially combines some of these elements. This is a systemic, attitudinal, motivational and reeducational, reorientation, training and supervision issue, which should be a key task of the AMIMH strategy outlined in recommendation 7 above.

11. Ample existing evidence replicated over more than 40 years suggests that complex co-occuring disorders including severe and persistent mental illnesses, ongoing substance abuse and physical illnesses, and unstable housing are best handled in the community by the **Assertive Community Treatment (ACT) team approach**, for which rural remote regional proxies can be developed, which include both telehealth and in-person team enhancements. ACT teams are the gold-standard of **active-response** (rather than passive-response) **case-management** or care coordination. ACT teams rely on low caseloads, crisis availability, 7 day-&-night mobile services, home visiting and active clinical and functional support. See Killaspy H & Rosen A 2011, and Rosen A Killaspy H & Harvey C, 2012. NDIS have been considering piloting our proposal to partner with public services in each region nationally to fund and operate combined ACT and support worker teams, including peer workers (Rosen A et al, 2019).

12. **Early Prevention and Early Intervention** services for ICE, poly-drug abuse and related mental disorders should be established in all regions following the approach set out by Matilda Institute submission, and the relevant chapter on this by Newton N, Dadds M & Teesson M, in Byrne P & Rosen A, eds, Early intervention of Nearly Everything, Blackwell-Wiley ,Oxford, 2014 (chapter attached with permission from authors).

13. **A new preventive mindset and approach re the scourge of ICE** is recommended. The more than 2.5X much higher prevalence of use in remote regions of Australia has been confirmed by surveys, wastewater studies and clinical presentations. It has been established that while there may not be an actual "epidemic", ICE use has represented a shift of existing drug use prevalence to much more potent forms of drugs, and

specifically to much more potent and dangerous amphetamines. There are undoubtedly many factors at play. Eg's: Ease of Manufacture, Distribution and Supply? Including via traditional criminal networks, gangs, growth of dark-web marketing with crypto-currencies, consumer feedback & on-line relations similar to the Amazon.com marketing model. Attenuated, too superficially spread policing? Gateway induction methods eg small amounts of Amphetamines in Cannibis supplies?. All these issues are examined in detail in **"Cracks in the Ice", The Mental Health Service Conference Summer Forum, Feb 2016** (Video lectures, powerpoints etc available to the Commission via Themhs Learning Network, Themhs Archives at www.themhs.org or via TheMHS Director, Ms Vivienne Millerdirector@themhs.org) The Matilda Institute, University of Sydney, national educational and intervention programs "Breaking the Ice", and "Cracks in the Ice" had their genesis in preceding TheMHS Summer Forums of the same titles.

14. Strategies to contend with both **Trauma and Stigma** are essential.
Advances in intervening with Trauma are now going well beyond "Trauma Informed Care" to neuroscience evidence-based "Trauma Specific Care". This applies particularly to developmental trauma in childhood, and rekindling through secondary trauma and vicarious trauma in later life.

Neuroplasticity-informed neuro-feedback courses appear to be especially promising (R Gurr, 2019, available on application). The common sources of trauma exacerbating ICE and poly-drug abuse and dependency are likely to be due to:

i) the acute disorder itself, whether extremely frightening drug trips, drug-induced or precipitated psychosis.
ii) the trauma of being held down for compulsory medicating and involuntary admissions. Often this may be remembered , while nether intoxication nor psychotic experiences are recalled at all.
iii) the avoidance, dehumanisation, stigma and discrimination, which service-users often recall as being worse than these disorders themselves.

Trauma, associated stigma and discrimination are experienced from early in the course of complex co-occuring disorders including severe mental health funcytional, physical and substance problems (McGorry et al, pers comm.).
Epigenesis or transgenerational transmission of all these sources of trauma by differential turning on and off particular genes, etc, across generations is under active study at present. This can lead to wasted life opportunities and loss of socio-cultural capital to the community and nation over many years. This is a crucial consideration in Indigenous communities (H Milroy, 2018-19).

15. **Aboriginal Mental Health & D&A services** should involve working **"two-ways"** (Professor Sir Mason Durie, Maori Mental Health & D&A leading psychiatrist) or "two-worlds" (Dr Mehl Madronna, US 1st Nations) or

Gayaa Duwii "Proud Spirit" Declaration (Australian National Mental Health Leadership Group, Thomas Brideson et al, 2016). This consists of working simultaneously in parallel to synergise Western evidence based clinical interventions and service delivery systems with traditional cultural healing approaches and extended kinship networks. Such a combination requires careful alignment and training to optimise healing and outcomes for complex and severe mental health & D&A co-occuring disorders. Qualified and/or trainee Aboriginal Mental Health Workers should be available to work alongside Mental Health & D&A professionals in the same team wherever possible to achieve the best and most enduring outcomes. Mental Health & D&A liaison workers should be available on-duty or on-call 7 days & nights each week to assist healthnprofessionals with Emergency Dept and in-patient admissions.

16. There should be **one combined, inclusive, respectfully and carefully negotiated community/region-wide mental health & drug & alcohol strategic plan**, encompassing public, NGO and primary health care (including GP practices, the PHN, Aboriginal Medical Services / Maari Ma, Justice/Corrections Health, and Royal Flying Doctor Service) and related services, including Police, Ambulance, Housing, Employment, Family Welfare and Benefits.

17. These and other measures should be designed to integrate the assessment, mental health, D&A and related physical care, whether in hospital, other residential facilities or in the community. The residual advantage of a remote location is that most service providers are likely to know each-other, and can be encouraged, enthused and attuned to the sense of working to **one coherent plan, to prevent duplications, overlaps and gaps in services.** It should be informed by the service mapping atlas of the Far West and other remote LHD MH Services (Spijker BA van, Salinas-Perez J, Mendoza J, Rosen A, Salvador-Carulla L et al, 2019). This process will help to diminish silo walls, and develop a culture of cooperation and integration with an efficient and effective division of labour.

So-called "dual disorders" are often much more in the service system than in the service users. To paraphrase Sane Australia's current submission statement on integration of services (July 2019) to Royal Commission into Mental Health Services in Victoria.

"We believe that our mental health, drug and alcohol and support systems should be designed to meet people's needs, **wrapping around them during times of crisis or complexity** - rather than requiring them to access support via multiple entry points and retelling their story numerous times**."**

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AR-6

This is the attachment marked "AR-6" referred to in the witness statement of Alan Rosen dated 23 July 2020.

Call for a comprehensive National Mental Health Plan to respond to the novel coronavirus (COVID-19) Pandemic

To:	The Hon **Greg Hunt** MP, Minister for Health; Professor **Michael Kidd**, Principal Medical Advisor, Commonwealth Dept of Health; Ms. **Christine Morgan**, CEO and Ms. **Lucy Brogden**, Chair, National Mental Health Commission; The Hon **Chris Bowen** MP, Shadow Minister for Health.

CALL TO ACTION: We urgently call on all Australian Governments to implement a comprehensive National Mental Health Plan to respond to the COVID-19 pandemic.

Context

- We welcome the well-timed and targeted first wave of mental health response from the National Cabinet, and States and Territory Governments, to the COVID-19 crisis.
- This initial package of funding has appropriately focused upon the whole population through crisis lines, and also on pivoting MBS funded primary and specialist mental health care to telehealth.
- We also acknowledge the relevant national guidance on mental health aspects of COVID-19 Pandemic from the Commonwealth Government and National Mental Health Commission. We also appreciate the decisive and unprecedented steps taken by the Federal Government to preserve livelihoods through the crisis via various economic stimulus packages. The safety nets that have been established are crucial to prevent loss of jobs, which harshly impact on people with more severe forms of mental illness.
- There is now an urgent need to move the focus to people with moderate to severe and/or complex mental illness, whose numbers will swell as the crisis unfolds.

Key issues

- The needs of people with moderate to severe mental illness were poorly served prior to the pandemic, as evidenced by a series of inquiries and most recently through the Victorian Royal Commission and the Productivity Commission Inquiry. This represents a pre-existing crisis and makes the system extremely at risk.
- Many people with mental illness and psychosocial disability were already existing on the margins of the economy and society, and are extremely vulnerable to an economic recession, and high levels of unemployment. Many are isolated or living with families in need of support themselves, and are at high risk of suicidal behaviour. At particularly high risk are Indigenous people, homeless people, non-citizens, and international students. Their need for acute care will swell during this crisis.

- A substantial rise in suicide risk is building, as in all economic recessions, and it will be more severe this time because of the scale and depth of the global disaster of COVID-19. The suicide prevention field and the National Mental Health Commission has been rightly emphasising the power of social determinants of suicide. The impact will be difficult to counter or moderate in the medium term. Our response therefore must turn much more strongly to freely accessible expert clinical care.
- In the shock of the initial phase of this pandemic, public mental health and many NGO services for people with mental illness have seen a sharp drop in face-to-face care, and a withdrawal from home based and assertive outreach modes of providing such care, just when these are most needed for a wider range of patients. In part this is related to a lack of availability of protection equipment and justifiable concerns about service-user and staff safety. It is also sometimes due to inconsistencies of clinical leadership and central policy direction, and loss of in-person clinical back-up for NGO support services in the community.
- The system is weakest at a point where it needs to be strongest in the context of COVID-19, namely in its capacity to work upstream with timely community interventions to prevent excessive emergency department presentations, and hospital admissions of acute mental illness.
- As with any disaster, and particularly one of the unprecedented scale in which we are now immersed, there will be a surge of new demand and need for care.
- Mental health services, including hospital facilities, will be overwhelmed if we do not intervene early, and intensively, with people we know to be at risk of acute episodes and suicide.
- The key solution is to urgently deploy evidence based mobile assertive community-based mental health services, including home based care with dynamic integration with digital and telehealth platforms.
- We call on all Australian Governments to ensure that national mandated policy guarantees an optimal balance between online and telehealth services, in-person mobile outreach community services, and hospital inpatient services. The focus of the next wave of policy and investment must shift to ensure the safety and optimal care of people with moderate to severe or complex mental illness.

Key Recommendations

1. Expand evidence-based mobile outreach community mental health services. The Hospital in the Home model of care is a key innovation that will help to prevent likely access block at hospitals and should play a central part in the next wave of mental health responses.
2. Further enhance digital and Telehealth technology to help minimise unnecessary person-to-person contact on safety grounds.

3. Ensure safety and personal support of all service-users, clinical and NGO providers. Mental health providers must be assured that there will be no retractions of community staffing or their outreach capacity, with strong and compassionate management support, thorough safety training, adequate supplies of personal protective equipment, regular supervision and pastoral mentoring, in full consultation with their industrial representatives.

Thank you for taking our growing concerns into account. We offer to help with all Australian Governments on the urgent implementation of these recommendations.

Signatories

- Professor Alan Rosen, Universities of Sydney & Wollongong, Chair, Transforming Australia's Mental Health Service System [TAMHSS].
- Professor Patrick McGorry, University of Melbourne, Executive Director, Orygen.
- Professor Helen Herrman, President, World Psychiatric Association [WPA], University of Melbourne, Former Director, St Vincent's MHS, Melbourne.
- Dr Tony Bartone, President, Australian Medical Association [AMA].
- A/Prof John Allan, President, Royal Australian & New Zealand College of Psychiatry [RANZCP].
- Ms. Melanie Cantwell, Acting CEO, Mental Health Australia.
- Professor Fiona Stanley, Patron, Telethon Kids Institute, UWA [tbc].
- Professor Ian Hickie, Executive Director, Brain & Mind Centre, University of Sydney.
- Ms Irene Gallagher, CEO, BEING: NSW Consumer Advisory Group-Mental Health, Inc..
- Professor Luis Salvador-Carulla, Director, Centre for Mental Health Research, ANU.
- Ms.Vivienne Miller, Executive Director, The Mental Health Services (TheMHS) Learning Network.
- Ms Lisa Sweeney, Chair, Australians For Mental Health [AFMH]
- Professor Frances Dark, Chair, (Qld)
- Professor Carol Harvey, Secretary,(Vic)
- Professor Lisa Brophy, Treasurer, (Vic)
- A/Prof Richard Newton, Executive,(Vic)

- World Association of Psychiatric Rehabilitation (Australia) [WAPR(Aus)].
- Dr Andrew Howie, immediate past Chair, RANZCP Rural & Remote Psychiatry Section, Adult Psychiatrist, Indigenous MH.
- Adjunct Professor Tom Callaly, Director of Medical Services, Mildura Base Hospital, Vic.
- Professor Patricia Dudgeon, Poche Centre for Indigenous Health, School of Indigenous Studies, University of WA.
- Indigenous Mental Health, Institute of Indigenous Studies, UWA
- Associate Professor Roger Gurr, Transcultural Community & Young Persons' MH & Trauma, Chair STARTTS, NSW.
- A/Prof Elizabeth Scott, Psychiatrist, Young Persons' MH, Notre Dame University.
- A/Prof Neeraj Gill, Adult Psychiatrist, Human Rights, Qld MHS.
- Dr. Michael Dudley, Adolescent MH, Refugee & Asylum Seeker MH, UNSW.
- Dr Paul Fanning, former CEO of LHD, former Area Director MHS, Epidemiologist, MH Nursing.
- A/Prof Peter McGeorge, Adolescent & Adult Psychiatrist, UNSW & Notre Dame University, NSW.
- Dr Sebastian Rosenberg, Brain & Mind Centre, University of Sydney.
- Mr.Tom Brideson, Indigenous Mental Health, NSW & National.
- Mr Kevin Kidd, MH Executive and MH Nursing, ACT Health.
- Mr Douglas Holmes, Super CRO Lived Experience Project.
- Dr Neil Phillips, Consultant Psychiatrist, Indigenous MH, NSW.
- Dr Steve Baily, Adult Psychiatrist, WA MHS.
- Professor John Hurley, Professor of Mental Health and Director of Higher Degree Research, Southern Cross University, Community MH Nursing.

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