Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF ASSOCIATE PROFESSOR SIMON STAFRACE

Aspirations for Victoria's future mental health system

1. BACKGROUND

1. I, Associate Professor Simon Peter Stafrace, MB BS, MPM, MHA, FRANZCP, Chief Adviser, Mental Health Reform Victoria, of 50 Lonsdale Street, Melbourne, Victoria, say as follows:

   a. I am presently on secondment to the Victorian Government until January 2022, as Chief Adviser, Mental Health Reform Victoria (**MHRV**) at 50 Lonsdale Street, Melbourne Victoria, 3000.

   b. In my substantive role, I am the Program (Clinical) Director of Mental and Addiction Health at Alfred Health, 50 Commercial Road, Melbourne Victoria, 3004.

   c. I hold an honorary appointment at Monash University as Clinical Adjunct Associate Professor.

   d. I have the following academic qualifications:

      i. Bachelor of Medicine, Bachelor of Surgery (MB BS) from the University of Melbourne;

      ii. Graduate Diploma of Mental Health Sciences (Clinical Hypnosis) from the University of Melbourne;

      iii. Master of Psychological Medicine from Monash University;

iv. Graduate Diploma of Health Services Management from Monash University; and

v. Master of Health Administration from La Trobe University.

2. I have had formal training in clinical hypnosis, rational–emotive behavioural therapy, single session family therapy, opioid substitution therapy, and community and health leadership.

3. I am a Fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

4. I was employed as a psychiatry registrar in the North Eastern Metropolitan Psychiatry Training Program from 1992 to 1996.

5. I was a consultant psychiatrist in private practice in Box Hill and Bundoora, with interests in depression, anxiety, structured psychotherapies and pharmacotherapy. I held admitting rights to Northpark Hospital, the Melbourne Clinic, and Delmont Hospital from 1996 – 2006.

6. I was employed as a consultant psychiatrist in older persons mental health at Bundoora Extended Care Centre (North-Western Area Mental Health Service) from 1996–1998; St George's Health Service (St Vincent's Health) from 1998 – 2000; and then as Director of Aged Psychiatry at Caulfield Hospital (Alfred Health) from 2000 – 2006.

7. I am presently co-chair of the RANZCP Community Collaboration Committee (since 2018); and a community member of the Victorian Government Department of Jobs, Precincts and Regions, Inner Southeast Metropolitan Partnership (since 2016). I was a board director of Tandem Inc, the peak body for Victorian mental health carers from 2016 – 2020; and a board director of Mental Health Victoria, the peak body for Victorian mental health service providers from 2018 – 2020.

8. As Chief Adviser at MHRV, I form part of an administrative office within the Department of Health and Human Services (DHHS) in the Victorian Government. It was established by the Governor–in–Council on 3 February 2020 for two years in order to implement the recommendations of the Royal Commission into Victoria's Mental Health System (RCVMHS)1. I report to the CEO, Ms Pam Anders, and provide high-level, expert clinical and service operations mental health advice to her, the broader implementation team and the Minister of Mental Health to ensure the work is true to the original vision and intent of the Royal Commission. Since the onset of the COVID–19 pandemic, I am also a member of the COVID-19 Mental Health Response and Recovery Governance Team, an executive collaboration of MHRV and the Mental Health and Drugs Branch (MHDB) within DHHS. Its purpose is to support the response of the Victorian mental health system to the pandemic, and ensure efforts are aligned and integrated effectively with the Health and Wellbeing COVID-19 Project Management Office (PMO), the State Health Emergency Management Team (SHEMT) and the recommendations of the RCVMHS.

9. As Program (Clinical) Director of Mental and Addiction Health at Alfred Health, I am responsible for the delivery of mental health and addiction services at 12 locations across southern metropolitan Melbourne2. These include infant, child, youth, adult, liaison–emergency and aged mental health services. The program is delivered through services provided at six community clinics, two hospitals, three residential units and a series of partnerships with community providers including Star Health, Access Health, Launch Housing, Wellways, Taskforce, Odyssey, Headspace National and the Southeast Melbourne Primary Health care Network (SEMPHN).

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[1] Victoria, *Victoria Government Gazette,* No G4, 30 January 2020, 199

[2] Since completing my last witness statement, Alfred Health decommissioned a clinic in South Yarra in 2019 and consolidated its community services on the one site in St Kilda Road, Melbourne, 3004.

10. I make this statement in my personal capacity rather than in my position with Alfred Health, DHHS or Monash University. I do this as the views I express in this statement, unless clearly identified as given in my capacity as Chief Adviser to MHRV, are my independent opinions based on my experience in clinical practice and health leadership across my career rather than in any individual role or position. Whilst my current role is as Chief Adviser to MHRV, I note that a substantial amount of this statement builds on matters set out in my previous statement to the RCVMHS in 2019 and relate to my previous position at Alfred Health. I have been assisted in compiling some of the evidence referred to in this statement, particularly in relation to matters that relate directly to MHRV by members of the team at MRHV, however the opinions and conclusions are my own.

11. This statement is true and correct to the best of my knowledge and belief.

12. Attached to this statement and marked 'SPS-1' is a copy of my curriculum vitae.

2. LEADERSHIP and REFORM

THE DISTINGUISHING FACTORS OF EFFECTIVE LEADERSHIP

> *"Our ambition to transform Victoria's mental health system into one that places people at the forefront, is responsive to an ever-evolving world, is trauma-informed and based on the best available scientific evidence is more pertinent than ever[3]."*
>
> *"…it's only through leadership you can truly develop and nurture a culture that is adaptive to change." John Kotter (1998)[4]*

13. In my 2019 witness statement, I was asked: "Do you have any views about how the (mental health) system can embed an attitude of change and constant learning?"; I wrote (paragraph 107): "…. Leadership matters greatly5." If the goal of mental health reform is to transform Victoria's mental health system into a public asset valued by the community, then leadership will be the key activity through which this will be delivered. And if located at its heart is a capacity for driving change, then the distinguishing features of effective leadership must surely be an ability to see the world from multiple perspectives, a vision for what might be possible, an openness to learning, and the courage to fail.

14. The objectives of effective leadership in Victoria's mental health system must be to:

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[3] RCVMHS, Statement from the Commissioners, 16 April 2020. At: < https://rcvmhs.vic.gov.au/news-statement-commissioners >.

1. [4]Kotter J (1998) "Cultures and Coalitions". In Gibson R (ed). Rethinking the Future: Rethinking Business, Principles, Competition, Control and Complexity, leadership, Markets and the World. London: Nicholas Brealey.

[5] Witness statement of Simon Peter Stafrace, 7 July 2019, para 107.

a) Articulate a purpose and a vision for the system, in which the priorities of its stakeholders are clearly present.

b) Access the resources and workforce needed to meet the expectations of stakeholders efficiently, effectively and justly.

c) Implement programs and interventions that reflect what matters to stakeholders and what is known about what works.

d) Change how the system operates, as evidenced through the attitudes and behaviours that are rewarded and celebrated; and

e) Improve how the system innovates, through the education, training, supervision, and coaching of each health, peer and social care worker; and in the use of data, audit, evaluation, and research.

15. **Effective mental health leadership is recognised by both its elements and its consequences**. It is fundamentally relational, and this is amplified in the mental health sector because the key interventions utilised depend substantially on human interaction, engagement and trust. It is distinguished by its impact on **the** culture and public value of organisations that provide mental healthcare. And finally, it will harness the authority, energy, and motivation of its stakeholder ecosystem. The latter begins with people with lived experience of mental illness. It extends to include clinical, peer and support mental healthcare workers; interdisciplinary researchers; public health policy specialists; and the communities that provide the contributions, infrastructure and networks required to support the ambition. Effective mental health leadership will create a safe space for stakeholders to participate in the co-design that will shape how the new system is planned, assembled and operated, echoing a clear message that has already emerged from the Interim Report of the RCVMHS.

BARRIERS TO THE DEVELOPMENT AND SUSTAINABILITY OF EFFECTIVE LEADERSHIP ACROSS THE MENTAL HEALTH SYSTEM

16. As an activity, leadership can be exercised by individuals, teams and organisations within the system. Barriers to its development and sustainability can be found at every one of these levels.

A. Organisational and Systemic Factors

17. **A key impediment is the systemic bias in decision-making that arises from the prioritisation of clinical, operational, financial and legal risk**. This is further influenced by a lack of diversity in leadership positions and legislated hierarchies. In order to illustrate this point, I would like to describe a study undertaken at Alfred Health of the allied health workforce.

18. Beginning in 2017, and in the context of a growing interest on the part of government to reform mental health services, Alfred Health commissioned a series of external reviews of its adult community, adult inpatient and adult sub-acute mental health services, largely focused on planning for service growth, capital development and improving the experience and outcomes of mental healthcare in the community and the hospital. In 2018, two developments provided a clear indication that the State government was committed to longer term reform. First, funding of core clinical adult services increased in real terms for the second consecutive financial year, allowing for sustained growth in infrastructure and services. Second, and more importantly, the RCVMHS was announced by the Premier with an undertaking to accept each of the Commission's recommendations. Alfred Health had long held concerns that the crisis-driven and risk-oriented approach that dominated adult mental health services was not meeting the needs of its community. The increased funding and commitment to longer term reform gave the service the confidence to explore a future in which it could rely on additional resources to deliver care that was not only accessible and efficient, but also person-

centred, more effective, less harmful and focused more explicitly on recovery and wellnes

19. A recurring theme in the consumer and carer consultations undertaken during these projects concerned the lack of therapeutic options in the care provided routinely to adults of working age. Earlier planning activities and consultations had already established that future growth of services had to improve the availability of psychological and other therapeutic services if it were to meet the needs and expectations of clients and families. In this setting, a review into Allied Health services and structures within the Alfred Mental and Addiction Health (**AMAH**) program was commissioned. The organisation wanted to understand whether its allied health workforce had the capacity and the organisational support to lead this reform in the future. The process involved multiple interviews and focus groups with allied health staff, their discipline heads, operational managers, executives and with consumers and carers.

20. The final report was completed in late 2019. Overall, allied health staff indicated that they liked working in the program and that they would recommend doing so to colleagues from other organisations. However, what emerged were differences in the allied health experience in the Alfred Health adult and aged mental health services on the one hand, and child and youth mental health services on the other.

    a) Many allied health clinicians working with adults and older persons expressed frustrations with clinical models of care that embedded medical and nursing authority, especially in the hospital setting. They referred to the dominance of medical and nursing leaders and the lack of senior operational managers with an allied health background. They spoke of the marginalisation of psychosocial models of care focused on strengths and recovery. They believed key decisions about patient care, such as discharge from hospital, were often made by doctors to manage demand and without careful consideration of allied health treatment objectives and advice. They believed that their inability to shape key treatment decisions was evidence

that the service was driven by factors other than the recovery of the patient, and that this created a moral hazard for some.[6]

b) The feedback from the child and youth programs stood in sharp contrast. Consumers and carers felt they benefited from a strong therapeutic program. The workforce told us that allied health staff were visible in leadership positions and had clear lines of responsibility. They told us that they believed they participated strongly in both clinical and operational decision-making and they were satisfied with the leadership opportunities open to them.

21. The clinical program leadership responded to the feedback by acknowledging that the findings did not represent where it wanted the adult and aged program streams to be, in terms of priorities and values. Changes were implemented to the organisational structure in order to embed senior allied health positions in the adult and aged mental health clinical units. A Deputy Clinical Services Director (Allied Health) position was created to report to the most senior operational Director in the program, with membership of the program Executive. Supervision and training for allied health and nursing were increased and were accompanied by an expansion of individual and family therapeutic services in the adult and aged community program streams. These changes were still being implemented at the time of writing. Though it is too early to account for their impact, I would like to share what lessons I believe can be drawn about barriers to effective leadership, from the findings of this study.

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[6] For the sake of completion, many nurses and doctors also provided feedback in the wider consultation process about their frustrations with how a focus on bed demand in the adult program shaped the model of care towards considerations of risk and patient flow, and away from therapeutic priorities. The allied health perspectives on the model of care I outlined earlier were not unique to that segment of the workforce.

22. The specialist child and youth mental health service has a large allied health workforce (including social workers, occupational therapists, psychologists, speech pathologists and exercise physiologists) that is well represented in the leadership team, including the most senior operational positions. This reflects the fact that care is entirely delivered in the community and the model of care is shaped by family and youth engagement, and brief psychotherapeutic interventions. Clinical risks are low. Having experienced substantial growth and redesign in the previous decade, tier 3 child and youth mental health services are now delivered in the same clinics as headspace primary and youth early psychosis specialist services. The vertical integration of primary health, mental health, drug and alcohol, and family and vocational services across several sites allows for better co-ordination of care for both clients and clinicians. There is now effectively no waiting period for the service and a capacity to meet growing demand. Less time is spent on managing access, client flow and cross-referrals, and there is a greater focus on delivering therapeutic interventions.

23. In contrast, the adult mental health program streams (inpatient, community and liaison-emergency) have a relatively smaller allied health workforce despite having a larger budget and client-base. Unsurprisingly, fewer leaders emerge from this segment of the workforce.

24. Although emergency demand had grown steadily each year over the previous decade, new investment in services had been relatively low until 2017. As a result, patients were admitted to hospital for shorter periods of time, without any additional support in the community post discharge. **The priorities of adult hospital and emergency services were therefore shaped by the following factors**:

a) **A disproportionate share of the financial, legal, clinical and operational risk.**[7]

b) **A lack of capacity to meet incident demand for emergency care and early intervention**, a problem identified by the RCVMHS in its Interim Report. As a result, the search for beds for adult patients awaiting admission in Emergency Departments typically dominates daily operational priorities.

c) **A model of care that favours risk management, statutory process and patient flow** in order to ensure timely access for patients presenting in crisis or requiring hospital treatment. Restricted budgets in the mental health system have placed limits on the size and seniority of the allied health workforce, with precedence being given to employing nursing and medical staff. Allied health workers in inpatient units are frequently inexperienced, have high turnover and receive insufficient supervision and education.

d) **A decision-making hierarchy institutionalised into practice by the *Mental Health Act 2014* (Vic)** (the **Act**). Statutory responsibilities enshrined in the Act require the authorised psychiatrist to make key judgements about compulsory treatment so that decisions about admission, leave, treatment planning, restrictive interventions, adverse incidents and discharge of patients on compulsory orders require authorisation by the psychiatrist.[8] This is useful in a resource-depleted system where treatment rationing

[7] In 2019-20, the adult hospital program accounted for 31% of budgeted revenue from state government to Alfred Health and 33% state-wide. This proportion more than doubles once adult community funding is considered.

[8] Though best practice requires that this is driven by consumer and family preference and is inclusive of multidisciplinary input, the Act sets up a hierarchy of control. This is amplified in the inpatient or emergency setting by the limited time available to work through differences within the multidisciplinary team (MDT) and by the high turnover of clients and largely part-time psychiatrist workforce. It is made worse by the relative inexperience of the early career nursing and allied health workforce in typical inpatient settings.

decisions need to be made quickly. It is less helpful in circumstances where there are enough beds and community-treatment options to meet the needs of the population and where a range of clinical and social therapeutic outcomes are being sought.

25. I believe that in many of Victoria's mental health services, the organisational and systemic factors that define what is important, how decisions are made, what is expected of the workforce, and what is celebrated mostly reflect the financial, legal, clinical and operational risks that dominate activity in the adult clinical streams. In order to attend to these priorities, adult mental health services employ a predominantly nursing and medical workforce. The success of doctors and nurses in managing the key organisational risks is rewarded by career advancement and access to leadership positions.

26. The frustrations expressed by the AMAH allied health workforce, with what they perceived as constrained models of care and limited access to leadership opportunities in the aged and adult service streams may serve as an indicator that leadership roles are being directed to people whose way of thinking about mental healthcare more closely reflects these priorities. If the ambition of the RCVMHS is for Victoria's mental health system to place people first and provide care that is trauma-informed and shaped by the best evidence, then I would argue a gap exists between what drives performance in the system and what is needed from it. That gap creates a barrier for effective leadership, whether this is provided by staff with a medical, nursing or allied health background. This is a wicked problem. Funding is not infinite and system design and resourcing can make it hard to manage competing priorities. I will come back to this topic and suggest ways to overcome these barriers in a more sustainable way, later in this statement.

B. Individual Factors

27. **Impediments to effective leadership may also arise from the leadership style or action logic favoured by individuals appointed to senior positions**. In

understanding how individual factors impact upon leadership styles, I have found the leadership development framework (**LDF**) described by Torbert and his colleagues[9] helpful. Based upon structured interviews of thousands of managers and professionals, Torbert identifies seven action logics that are made up of three elements:

a) A cognitive (or thinking) dimension that describes basic assumptions leaders make with respect to themselves, their relationships, and the world around them;

b) An affective (or feeling) dimension that describes their sources of happiness and satisfaction and what triggers feelings of anxiety, depression and threat; and

c) A behavioural (or doing) dimension, that describes how leaders respond to challenges to their power and safety.

28. The seven action logics are typically presented as a hierarchy, but this doesn't completely capture how each action logic is built on earlier stages of development and how individuals are dynamic, with an ability to expand knowledge within each domain, and regress or progress between developmental stages. In addition, the seven action logics are not found in isolation of one another. Typically, individuals exhibit elements of multiple domains, weighted predominantly across one or two, with a capacity to regress to earlier stages under stress. I will describe each action logic in turn. The numbers in parentheses indicate the prevalence of each dominant action logic in the samples profiled by Rooke and Torbert.

[9] Rooke D and Torbert WR. Seven transformations of leadership. Harvard Business Review (2005) Apr; 66-76.

29. Opportunists (5%) are egocentric, mistrustful and manipulative and tend to focus on personal wins. This is referred to as a pre-conventional action logic, and is rarely found in healthcare leaders, though elements may be.[10] Most managers and leaders (80%) function within what are known as the conventional action logics. These involve linear reasoning and progress towards an increasing capacity to adopt different perspectives about one's self and one's interests and to strive towards goals. Diplomats (12%) perceive their interests in relational terms.[11] Experts (38%) focus on evidence and data.[12] In the healthcare setting, they can be extraordinarily productive as clinicians, but struggle leading teams of people with diverse capabilities and different perspectives. Finally, Achievers (30%) focus on targets and objectives. They understand that the world is complex and realise that creative transformation requires sensitivity to relationships, conflict resolution and the ability to influence others in positive ways. On the downside, this style often inhibits thinking outside the box.[13] Post-conventional action logics tend towards deeper understanding and a capacity to perceive and manage dynamic systems. Individualists (10%) are comfortable with ambiguity and can adapt quickly to

[10] They perceive people as opportunities to be controlled and exploited. Their reaction to events depends primarily on whether they can direct the outcome. Opportunists rationalise their bad behaviour as legitimate in a competitive world. They reject feedback, externalise blame and retaliate harshly. Their style of leadership involves self-aggrandisement, frequent rule breaking to win at all costs and constant firefighting.

[11] They focus on controlling their own behaviour, keeping people happy and avoiding feedback and disputes. They distrust outsiders, and place a high value on approval, belonging and connection. They stick to rules and avoid rocking the boat unless group norms and cohesion are threatened. Most diplomats work at a junior level and contribute to social cohesion. They are problematic in top leadership roles because they ignore conflict and the need for change.

[12] They value individual effort, technical knowledge and being right over motivating and engaging others and they derive satisfaction from winning arguments and being recognised for their expertise. Their contribution manifests through technical proficiency and excellence and dedication to craft.

[13] They accept and implement strategic goals and see themselves as agents of change. They welcome feedback, create a positive working environment and achieve outcomes through people and teams.

changing circumstances.[14] The final two action logics drive transformation. While strategists (4%) influence personal and organisational change, the impact of alchemists (<1%) is social. Both action logics are centred on an understanding of complex adaptive systems. Strategists engage with different action logics and create shared visions that activate and energise others. They "play" at the interface of personal relationships, organisational relations and social developments and drive their organisations beyond narrow self-interest. Alchemists build on the strategist action logic. They deal with multiple situations at multiple levels and show an enormous capacity to reinvent themselves and their organisations in ways that drive social transformation.

30. **Within the healthcare system, change and reform will rely upon the combined efforts of leaders with conventional and post-conventional action logics working in harmony**. Experts strive to develop and improve their craft and put into practice existing and new knowledge. Achievers drive organisations towards goals and objectives. Individualists harness the perspectives of multiple action logics. Strategists and alchemists with their broader, systemic frames and their capacity for looking to and over the horizon, bring about transformative change.

31. **Achieving a balance of action logics at different levels of the mental health system will be a key to achieving reform**. Sustainability and progress will require that a pipeline of leaders is created who can progress through the developmental stages through experience, education, coaching, mentorship and training. The achiever and expert action logics are as common in medical, academic and operational mental health leaders as Torbert and others showed they are in the samples of managers and leaders they surveyed across multiple sectors. But this

[14] They hold different frames of reference in their thinking and regard objectivity as a myth. They work through complex processes, understanding themselves and others. They are often unorthodox and act outside the box. They can deal with complexity and paradox. Individualists "get" colleagues with different action logics, but struggle to manage up and to deal with the organisational implications of their behaviour.

will not be enough to drive sustainable reform in the complex adaptive systems that mental health services (functioning in globalised and diverse communities) have become. I believe that effective senior leadership, at the systems and service level, will increasingly depend on people who can transition from expert and achiever to individualist and strategist action logics, and the organisations that can enable this to occur.

STRUCTURES AND MECHANISMS NEEDED AT BOTH A SERVICE AND SYSTEM LEVEL, TO OVERCOME THESE BARRIERS ON AN ENDURING BASIS

32. I have already written earlier in this statement about the way in which Victoria's mental health system has favoured a style of leadership that is highly focused on managing the primary financial, legal, clinical and operational risks. Success in managing these risks is valued, measured and rewarded. Paradoxically, when the demand on services far exceeds capacity and activity-based or financial signals that can generate an appropriate response do not exist, then these risks are amplified. Management becomes focused on operational interventions that reduce demand without adverse impact to measured health service performance, even when this leads to poor health system performance and negative consumer and social outcomes. Favoured, and socially successful management styles emerge that are hierarchical, procedure-driven, results orientated, and typically favour expert and achiever action logics. These are then adopted even by leaders who are capable of using post-conventional action logics. The outcome is to move the system ever farther away from the vision of the RCVMHS.

33. **The challenge for the system is to create incentives to shift health service culture towards valuing what good mental healthcare looks like**. The process of reform and system redesign being undertaken by the Commission will be critical in achieving this outcome. While I cannot imagine a system that operates without a concern for safety, demand management and the legal and regulatory environment, I do believe that the following initiatives could allow services to provide more appropriate care by creating incentives for different organisational priorities.

a) **Improved capacity in adult services** will reduce the pressures of patient flow that presently shape what is valued by organisations and reduce the compromises to care and moral hazards that come about when patient access to care trumps patient recovery. This can be achieved through increased bed numbers, alternatives for walk-up treatment other than the emergency department, the redesign of community services to provide alternatives to hospitalisation, options for intensive acute step-up and step-down community care and adequate housing and long-term care. If service leaders can spend less time dealing with basic demand issues, they will be able to dedicate more effort to strategic, long term issues than is presently the case.

b) **Challenging the exclusive role of the psychiatrist in decision-making about compulsory patients**. Mental health legislation should allow for delegation of non-psychiatrists. This would allow for more diverse inputs into clinical decision-making especially in relation to community-managed consumers. An authorised psychiatrist should still be appointed to each area mental health service in order to create single point accountability for clinical governance. The authorised psychiatrist should be given powers to designate other psychiatrists and/or nurses and allied health practitioners, as delegated or authorised clinicians. Such arrangements exist in WA[15] and Queensland.[16] Nurses and allied health clinicians should only be eligible for delegation by completing specific training and having a set minimum number of years of clinical experience in hospital, community or emergency

[15] Office of the Chief Psychiatrist, Western Australia. How to become an Authorised Mental Health Practitioners At: https://www.chiefpsychiatrist.wa.gov.au/authorisations/authorised-mental-health-practitioners/amhp-education-and-training/

[16] Queensland Health. Mental Health Act 2016, Chief Psychiatrist Policy, 'Appointment of authorised doctors and authorised mental health practitioners' < https://www.health.qld.gov.au/__data/assets/pdf_file/0032/636854/cpp_appointment_ad_amhp.pdf >.

mental health services. Professional development and supervision requirements are also requirements of the role. The advantage of such an arrangement is to avoid concentrating clinical power in the hands of a single profession and to create cross-disciplinary conversations in matters relevant to compulsory orders. This will better represent a broader range of client needs and priorities that must be considered in decisions about limiting the autonomy of the client and may better open the team to engaging with clients and their families about what matters to them. In the same way and for the same reasons, clinical advice about compulsory treatment should more explicitly represent the input of a multidisciplinary team to the Mental Health Tribunal, with recommendations by multidisciplinary teams being signed off by an authorised clinician.

c) **Performance indicators that better reflect client and family experience of care, client- and family-reported outcomes, and the delivery of evidence-based treatments including psychological and social interventions**. Rosenberg et al (2015) have written about the use of performance data to drive reform and have described the existing system of reporting as fragmented and outcome blind. They proposed 12 indicators that emphasise proximal factors that can drive reform as opposed to distal factors such as complex determinants that act over longer time frames. These include health, social and system domain indicators.[17]

d) **Funding reform to create models that pay for elements of care valued by consumers and carers**. This is critical and I would like to elaborate on this subject further.

[17] Rosenberg SP, Hickie et al. 'Using accountability for mental health to drive reform', *The Medical Journal of Australia* 203 (8) (2015), 328-330.

34. **Funding models shape organisational values and preferences** and therefore could be a major instrument in driving the reform objectives of the Royal Commission. A case mix funding model for mental health could result in several long-term benefits for the sector. These could include:

a) Matching resources to need more fairly, by linking the volume of service hours to the needs of the consumers who use the service;

b) Maintaining the value and impact of new investment in mental health by providing a mechanism for annual budget adjustment based on predictable volumes and profiles of demand;

c) Aligning funding to evidence-based care, using outcome measures to track impacts over time; and

d) Driving more efficient resource use by tying funding to expected service levels.

35. Other case-mix funding systems in acute care are based on diagnosis, which is a strong predictor of resource use in physical health but not mental health. The new national classification of mental health care, the Australian Mental Health Care Classification or AMHCC, has been developed for this purpose, but still needs refinement. There are significant gaps in recording of mental health wellbeing measures, such as the Health of the Nation Outcomes Scales and Life Skills Profile, and the resource intensity of community contacts. This is especially problematic for adult community mental health care, where clinical practice varies greatly, and cost data is very poor or missing. **A more demand-sensitive and accountable funding model in the community will strengthen community alternatives to inpatient and emergency care**. The Independent Hospital Pricing Authority (**IHPA**) is moving to shadow price inpatient mental health using the AMHCC in 2020-21 but has considered community mental health care too problematic in terms of cost and complexity data gaps to price and shadow fund at this stage.

36. I do not wish to underplay the size of the task needed to develop an activity-based funding model for mental health. There is no precedent for this in Australia or to the best of my knowledge, globally. **DHHS has been working on a project, the Clinical Funding Reform Project, to this end for some time and should be supported to complete this endeavour as a matter of priority**. The Productivity Commission recommended that the IHPA should consider developing a classification system for community ambulatory mental healthcare services based on hours of care provided[18]. I am also aware that the Productivity Commission into Mental Health will include recommendations about funding for mental health in its final report, and this will no doubt shape the policy landscape considerably. There must be an equally substantial effort to develop the training, IT and workforce needed to support such models once completed. Neglecting just one of these areas will compromise them all, and that will damage the capacity of the system to undertake and preserve wider reforms.

37. **The importance of this work for mental health reform and by extension, to shifting leadership and organisational culture within the Victorian system cannot be overstated**. The lack of an activity-based funding model which pays services for what they do, and holds them accountable in a funding sense for what they actually deliver, is likely to have been a major reason why mental health has fared so poorly in attracting the funding that is needed to deliver the care that is valued. And without this foundation, a focus on service quality and outcomes will fail to drive the behaviours and attitudes that will facilitate the effective leadership the system needs to drive reform.

38. Health service chief executives and board members must take as much interest in what good looks like as they do in what goes wrong. It is only then that an approach to leadership can emerge that favours effectiveness, person-centredness

[18] Productivity Commission, *Draft Report on Mental Health: Volume 2*, October 2019, p. 937 (Recommendation 231).

and recovery as much as it does clinical safety and financial, legal, and operational risk. Improving system capacity, and changing what is paid for, what is measured and how clinical decisions are made will change organisational priorities and by extension, favour the kinds of leadership behaviours that will bring about mental health reform.

39. I will consider the structures and mechanisms needed to overcome the barriers to effective leadership that arise from individual leadership competencies later in this statement.

THE IMPORTANCE OF SERVICE AND SYSTEM LEADERSHIP TO THE SUCCESSFUL IMPLEMENTATION OF TRANSFORMATIONAL AND ENDURING REFORM TO VICTORIA'S MENTAL HEALTH SYSTEM

40. I have already set out above the impact of individual and organisational factors on effective leadership. These factors influence one another in ways that are reciprocal, such that the leadership of individuals influences teams and organisations, and organisations and teams shape and influence leadership behaviours in individuals.

41. Leadership is necessary for the transformation of Victoria's mental health system, through its capacity to foster change and innovation in individuals, teams, organisations and systems. Left unchallenged, organisations become static and dysfunctional in the face of continued external change. Leaders are required to communicate a vision of a better future, and to inspire and empower others to challenge the status quo in a form of co-creation.

42. The role of those who supervise individuals providing direct services, so-called first line leadership, is especially critical to organisational effectiveness. Corrigan et al (2000) described a study of 143 leaders and 473 subordinates, from 31 mental health clinical teams who rated the leadership style of the team leader. Three types of team leadership were identified. These were transformational leadership, in which a leader's primary goal is to lead the team to evolving better programs by responding to the changing needs of clients; transactional leadership, in which the leader strives to maintain effective programs through goal setting, feedback and reinforcement; and laissez-faire leadership, an ineffective hands-off style. The findings showed that transformational leadership was positively associated with measures of the team's functioning, and with consumer satisfaction and quality of

life. Laissez-faire leadership, in contrast, was associated with low consumer satisfaction and poor quality of life[19].

43. Evidence also supports the importance of first-line leaders in the implementation process. Studies of surgical teams have demonstrated that effective leadership can set the stage for positive team functioning and psychological safety and inclusion that facilitates effective implementation of innovative healthcare procedures. Effective leadership supports implementation of person-centred care in nursing homes and hand hygiene in hospital settings. Transformational leadership is important for developing a climate for innovation and positive attitudes towards evidence-based practice during large-scale implementation. Reviews and observational studies in nursing have supported the role of leadership in the promotion of evidence-based practice and in influencing the use of practice guidelines.[20]

44. At more senior levels, leaders change culture through what Schein described as primary and secondary mechanisms. Primary embedding mechanisms are denoted by what senior leaders pay attention to, measure and control on a regular basis; how they react to critical incidents and crises; and how they allocate resources and reward, recruit and promote individuals in their organisations. Role modelling, teaching and coaching also matters in this regard. Secondary reinforcement and stabilising processes include organisational design and structure, systems and

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[19] Corrigan PW, Lickey SE, Campion J and Rashid F, 'Mental health team leadership and consumers satisfaction and quality of life', *Psychiatric Services* 51 (6) (June 2000), 781-85.

[20] Aarons G, Ehrhart M et al. 'Leadership and organisational change for implementation: a randomised mixed method pilot study of the leadership and organisation development intervention for evidence-based practice implementation', *Implementation Science* 10, 11 (2015). < https://doi.org/10.1186/s13012-014-0192-y >

procedures; rites and rituals; and making sense of what is happening through stories.[21]

45. In summary then, people exercising leadership at the team or senior level can influence outcomes for the better. In so doing, they will shape the pattern of beliefs, values, and behavioural norms that represents the shared learning of the organisation as it solves the problems it confronts. This accumulated learning is recognised as the culture of an organisation. If sufficiently and consistently generalised across several organisations undertaking similar tasks in a coordinated network of public services, it may be described as the culture of a system.

46. Just as leaders influence culture, so too can organisational culture shape leaders, either by constraining them or by enabling and amplifying the impact of certain leadership styles and attributes.[22] Parry and Proctor-Thomson (2003) used two national leadership surveys to test hypothesised relationships between manifestations of leadership, culture type and effectiveness in the public sector in New Zealand. The data provided support for the proposition that individual or team leadership AND organisational culture have a reciprocal relationship upon each other, and that both affect organisational outcomes. The fact that these account for just over 50% of the variance is a reminder that other factors, many of them external, also influence public service outcomes. The authors concluded that the findings suggest that two main strategies should be considered to improve outcomes. The first is to develop leadership within individuals and teams and will

[21] Schein, EH, *Organisational culture and leadership*, 5th Edition (Hoboken: John Wiley and Sons, 2017).

[22] Hampden-Turner C. *Corporate culture; from vicious to virtuous circles* (London: Hutchinson Business Books, 1990).

achieve by far the greater impact. And the second is to work on the culture of the organisation to create the conditions that allow leadership to be displayed.[23]

47. Given that leadership can be exercised at any level of an organisation and that organisational culture can create conditions for leadership to develop, it follows then that leadership has its greatest impact as an instrument of systemic change when it aligns with strategy, policy, resources and organisational culture. I have used the term strategy here to denote an activity through which governments and organisations articulate the most important issues they confront and set the goals they will implement and achieve.[24] Policy creates the framework of principles that guides what governments and organisations do to reach their strategic goals.[25] Leadership uses policy and organisational culture as leverage to achieve the aims of strategy.

48. I previously referred to this idea that leadership is effective when it is aligned with strategy and organisational culture, in my 2019 witness statement when I wrote:

> *"The motivation to implement these initiatives [at Alfred Health] starts with an organisational culture that demands excellence, and rewards innovation and creativity. It is supported by leadership at the level of the Board and the Health Service Executive, who seek solutions to difficult operational problems, are open to new ideas and are willing to provide resources and take risks. It is implemented by clinicians and more recently peer workers at the service delivery level who are engaged in the design of the initiatives and open to change. And it requires a substantial investment in training,*

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[23] Parry K and Proctor-Thomson SB, 'Leadership, culture and performance: the case of the New Zealand public sector' 3(4) *Journal of Change Management* (2003), 376-399.

[24] Johanson JE, *Strategy Formation and Policy Making in Government* (Palgrave MacMillan, 2019).

[25] Buse K, Mays N and Walt G, *Making Health Policy*, 2nd Edition (Open University Press, 2012).

supervision and evaluation to ensure that models are deployed faithfully, feedback is sought and responded to, and processes are improved in response to the evidence[26]*."*

CAPABILITIES AND SKILLS REQUIRED BY LEADERS TO DRIVE AND OVERSEE REFORM

49. Ideas about leadership have come a long way since Astrachan (1980), then a Professor of Psychiatry at Yale University, wrote: "*...the future of healthcare organisations lies in their members' clinical competency and commitment to excellent practice, but is also dependent on their knowledge of such administrative tasks as planning, budgeting, and the management of physical plant and its employees.*[27]" Nearly 40 years later, Ng et al (2018) recognised that though there is no single prototype for leadership in psychiatry, emotional intelligence combining self-awareness, self-regulation and empathy, and a high level of technical skill are critical elements of psychiatric leadership.[28] McNeish and Tranh (2020)[29] looked at interdisciplinary programs in 16 local communities, involving community partnerships and community members, aimed at improving the mental well-being of men and boys. They found that a strong personal vision; an orientation towards values, relationships and operational outcomes; and the development of leadership capability independent of technical proficiency were the five leadership qualities that contributed to the success of these programs. I would like to reflect on these findings further.

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[26] Witness statement of Simon Peter Stafrace, 7 July 2019, para 128.

[27] Astrachan BM, 'Regulation, adaptation, and leadership in psychiatric facilities', *Hospital and Community Psychiatry* 31(3) (1980), 169-174.

[28] Ng L, Steane R, Scollay N. 'Leadership mindset in mental health', *Australasian Psychiatry* 26(1) (2018), 95-97

[29] McNeish R and Tran Q. 'Leadership that promotes successful implementation of community-based mental health', *Journal of Community Psychology* 48(5) (2020) <https://doi.org/ 10.1002/jcop.22343> .

50. I believe that technical mental health and operational competencies are necessary in mental health leadership, but they are not sufficient. Technical challenges are easy to identify and amenable to expertise. They do not require substantial organisational or personal learning or behaviour change. They often lend themselves to relatively straightforward linear solutions that can be implemented quickly and/or by edict. People are often receptive both to the solutions and to the experts who propose them. Adaptive challenges, on the other hand, often involve a disparity between circumstances and values, and typically cannot be resolved using technical means alone. Solutions may require a consideration of values, beliefs, roles, and relationships. The work of solving adaptive problems is often done by the people with the challenge. Responses to adaptive challenges typically require experiments and new discoveries that can take a long time to implement.

51. Delivering mental health services successfully is above all an adaptive challenge at both the clinical and organisational levels. This means that stakeholders (patients, families, clinicians and communities) are required to identify problems that are often unique to the patient,[30] implement solutions to complex problems through action and behavioural change; and negotiate trade-offs. The difference between the technical and adaptive elements of leadership is one that I think lies at the heart of effective leadership in the mental health sector. An ability to recruit adaptive leaders or develop adaptive leadership capability will be crucial in building the capacity for reform in our mental health sector. And yet, in my experience, technical

[30] An assumption about the uniqueness of the problems with which patients present is the basis of the formulation in psychiatry, which is seen as complimenting a diagnosis using a standardised classification such as the International Classification of Diseases (10th Edition) or ICD-10. The formulation is a summary of the patient's story which presents the patient's presenting symptoms as the culmination of a journey that draws upon genetic, familial and developmental factors, including trauma, that may have predisposed to the presenting complaint, and identifies biological, psychological and social factors that may have triggered the complaint or may act as risk factors to its continuation or protective factors that could bring about its resolution.

competencies are more explicitly and consistently sought when health services recruit people to senior leadership positions.

52. The difference between technical and adaptive challenges are starkly evident in the response of nations to the 2020 coronavirus pandemic. The technical challenges seem relatively straightforward. A cure may be possible when a vaccine is identified, and substantial efforts are underway to facilitate this. Treatment of the most serious complications of COVID-19, including severe adult respiratory syndrome, has improved during the pandemic. Mortality rates are lowest when hospitals and critical care units are not overwhelmed by demand and ventilators are available in large enough numbers to allow for the treatment of patients who require intensive care. Prevention of the disease and control require social distancing, hand washing, testing, contact tracing and isolation/quarantine.[31] And yet, outcomes have been vastly different. The preparedness of communities to subject themselves to prolonged isolation has varied widely. Mixed messages from political leaders in Brazil, Iran and the USA have led to lower rates of compliance with basic public health control measures and higher infection rates per capita in those countries. The capacity of health services to respond to the massive spike in demand due to the respiratory, vascular and neurological complications of COVID-19 has reflected the pre-pandemic performance and strength of public health systems in affected countries, and indeed the capacity of political institutions to make decisions rapidly about consequential matters. The ability of societies to withstand the calamitous economic, social and political impacts has been shaped by the wealth of nations; economic and racial inequality; social and cultural belief systems; access to affordable health and social care; government support of incomes and employment; and training for re-entry into the economy. The adaptive

[31] Australian Government Department of Health, *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)* (2020, Australian Government Department of Health) < https://www.health.gov.au/sites/default/files/documents/2020/02/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19_2.pdf >

challenge of COVID-19 required communities to make choices about whether protecting health and saving lives is worth the personal, social and economic cost. The technical challenge of preventing and treating the infection is similar in each country, but the adaptive challenge draws on an infinite number of individual, interpersonal, social, cultural, political and economic factors unique to each community. This ultimately has and will continue to influence outcomes.

53. Adaptive leadership in mental healthcare builds on a technical understanding of mental health and mental illness by placing the client in an overlapping space where genetic, psychological and interpersonal factors intersect with personal values, the healthcare environment and society. An adaptive response to the changing needs of the client requires interventions that take into consideration the priorities of different stakeholders and lead to a common understanding of what thriving entails in the setting of a new environment. It builds on the past, changes through experimentation, draws in diverse perspectives, and ultimately discards tightly held beliefs in a process that may generate feelings of loss and grief and resistance to change.[32]

54. Adaptive challenges are not unique to the mental healthcare setting. Thygerson et al (2010)[33] wrote that adaptive leadership promises to improve the practice of medicine through a perspective that frames patients as complex systems facing both technical and adaptive health challenges. They warn that a failure to recognise this leads to ineffective and inefficient healthcare that injures patients and wastes resources. I would argue that the same can be said about the practice of psychiatry, the medicine of mental ill health.

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[32] Heifetz R, Grashow A and Linsky M., *The Practice of Adaptive Leadership. Tools and tactics for changing your organisation the world* (Harvard Business Press, 2009).

[33] Thygerson M, Morrissey M and Ulstad V., 'Adaptive leadership in the practice of medicine: a complexity-based approach to reframing the doctor – patient relationship', *Journal of Evaluation in Clinical Practice* 16(5) (2010), 1009 – 1015.

55. Adaptive thinking assumes that systems are never broken, but rather perfectly designed to achieve the outcomes they produce. I made this point in an op-ed published in 2018[34] and firmly believe that in 2020, the system is still producing exactly the result it was designed to do. The first task of adaptive leadership then is to diagnose why the system is not producing the results the community needs from it. I have tried to do that in this witness statement in my reference to the financial, legal, clinical and operational risks that shape mental health organisational and systems priorities in Victoria. I have suggested that this shapes the leadership hierarchy, where power lies and what drives the status quo. Heifetz, Grashow and Linsky (2009) described four archetypal adaptive challenges faced by organisations, which I believe can be found in Victoria's mental health system:

a) Gaps between espoused values and behaviours emerge when a service that strives to be "patient-centred" fails to support decision-making by consumers and imposes obligations that have not been negotiated with consumer input and do not place the needs of consumers first;

b) Competing commitments are evident when clinicians strive to respect the dignity of risk and limit restrictive treatments, and then choose to deploy coercive treatment to minimise the possibility patients could be harmed by their own actions or as a result of accidental neglect during acute episodes of illness. Risk aversion may be driven by the fear or lived experience of being publicly sanctioned by the coroner, investigated by multiple oversight bodies in relation to the same issue, or sued for damages in civil courts. In my role as a Clinical Director, I have witnessed clinicians being subjected to all these outcomes;

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[34] S Stafrace, 'The mental health system was never broken- it was built this way', *The Age*, 27 October 2018. < https://www.theage.com.au/national/victoria/the-mental-health-system-was-never-broken-it-was-built-this-way-20181025-p50bup.html >

c) Speaking the unspeakable occurs when MHS with high rates of restrictive interventions argue that their clients are more aggressive and impulsive than elsewhere, and then ignore problems with high staff turnover, a lack of scrutiny of existing practice and a lack of investment in staff supervision, reflective practice and training;

d) Avoiding change that generates intolerable discomfort is evident when clinicians argue that they cannot introduce family-sensitive practice because it takes too much time, there are too many patients who demand confidentiality, and some families are difficult.

56. Adaptive leadership emerges from a systems perspective of mental health service delivery and leads to action to mobilise the system purposefully. This can be achieved through what leaders say and do; in a leader's awareness of motivations, triggers, loyalties and tolerances in oneself and in others; and finally in a leader's capacity to use one's impact on the system intentionally through connection to purpose, courageous engagement, authenticity and risk taking. The techniques of adaptive thinking can be taught and learnt.

SUPPORTING EMERGING LEADERS TO DEVELOP THE REQUISITE CAPABILITIES AND SKILLS

57. Leigh et al (2014)[35] undertook focus group interviews involving 25 out of 80 community health leaders, who attended a community clinical leadership development program in the UK. Three key themes emerged that influenced the development of best practice principles for clinical leadership development. These were 1) personal leadership development; 2) organisational leadership; and 3) the importance of multiple professional action learning/reflective groups.

58. I have already spoken about organisational leadership and its impact on individual leadership development. I would now like to turn my attention to individual leadership development and draw out the three leadership tracks I followed in my own leadership journey in the mental health sector, by way of example. Having completed my qualifications in medicine and psychiatry, I worked as a clinician in the public health and private sectors before deciding, as an early career psychiatrist, to pursue an interest in leadership and management. Without intentionally setting out a roadmap ahead of time, I followed a path that should be familiar to many healthcare leaders, made up of three intersecting elements that have profoundly shaped the direction my journey has taken.

59. The first is represented by the leadership experience that I gained through my appointments as a consultant psychiatrist, unit head, program clinical director, and adviser in DHHS. The journey must be underpinned by **experience**. Leadership is forged when difficult decisions are made, people are engaged, and the lessons of success and failure are reflected upon and used to shape future attitudes and beliefs. Healthcare leaders must take opportunities to lead teams, clinical units and

[35] Leigh JA et al., 'Transforming community services through the use of a multidimensional model of clinical leadership', *Journal of Clinical Nursing* 24 (5-6) (2015), 749-760.

programs and health and social organisations where decision making has real life consequences for clients and their families, healthcare workers and communities.

60. The second has involved a relatively structured and bounded process of developing a set of **technical competencies** through numerous workshops, skills-based programs, and academic qualifications in health services management. Technical competencies can be acquired through to high-quality structured programs, delivered by education and training providers, professional colleges and academic institutions. There are several factors here that need to be considered, specifically; healthcare workers must have access to these programs, time to engage in these activities, and funding to pay them.

61. The third is represented by the ongoing development of **adaptive leadership skills**, through coaching, mentorship, action learning and reflective practice. These activities have been embedded in the academic, community and global health leadership programmes I have undertaken, or I have sought them independently. An important outcome of these activities for me has been working towards an understanding of my strengths and limitations and my interpersonal and systemic impact. A key objective of ongoing adaptive work is to effect change for the better in myself and my impact on people, organisations and communities. It is a process I will be engaged on, no doubt, for the rest of my career.

62. I believe that all three elements are required in order to support and encourage emerging leaders to develop their leadership skills. There is no specific order in which they should be tackled, and leaders will switch from an emphasis on one or the other and back again, at different phases of their career. A central feature of the three leadership 'tracks' is that each involves the learning that comes from reflecting and problem solving with peers and mentors. And with the exception of the leadership experience that comes from working in senior roles in the mental health sector, the other two leadership 'tracks' should involve interacting with peers and mentors from other disciplines in health, including peer-led disciplines, and from sectors outside of mental health, including other areas of health, the community and business sectors, and beyond. This is critically important, as leadership development should push participants towards adaptive divergent thinking and

away from technical convergent solutions. This comes more naturally in settings that do not easily assume the hierarchies and cognitive frameworks of the dominant work culture.

63. In thinking about a leadership development framework to support the emergence of adaptive leadership in the mental health setting, I would suggest that thought needs to be given to frameworks at the levels of (health and human service) systems; (health and community service) organisations; mental health services; and individuals. Further, the responsibility for crafting an approach to leadership development should sit as much with individuals as with organisations. There is no one size fits all and a top down approach to leadership development carries risks and could stifle creativity. That said mental healthcare workers in leadership positions should have leadership development formally integrated into their professional development plans and should have the time and resources to pursue appropriate activities. Leaders should think broadly about what is appropriate, while keeping an eye out for the ridiculous.[36]

64. The RCVMHS Interim Report provided a 'Workforce Readiness' recommendation which stated in part that the Victorian government should prepare for workforce reform by providing:

> *a 'mental health leadership network' with representation across the state and the various disciplines, including lived experience workforces, supported to participate collaboratively in new learning, training and mentorship opportunities.*

[36] A cruise to the Antarctic as part of a program titled "Leadership for Healthcare" could reasonably be rejected as inappropriate on the basis that it appears to be principally organised around a leisure objective and not a professional one.

There is an argument that the mental health system operates with historical and ingrained hierarchies that limit the capacity for collaborative, system-wide reform. Reformed leadership across all levels and disciplines will be essential for responsive workplace cultures to be established and the system to be successfully reformed. Collaborative, engaging and innovative leadership is crucial to promote cultures of continuous quality and safety improvements and to create positive and engaging workplace cultures. Within disciplines of the mental health workforce, low staff retention has been attributed to a perceived lack of professional development opportunities and career progression, which affects the leadership pipeline and workforce readiness to reform. In addition, lived experience leadership is inconsistently integrated into service delivery, quality and safety, and implementation structures and processes.

65. MHRV has commissioned the Victorian Centre for Mental Health Learning to develop a concept and model development paper for a Victorian mental health leadership network that covers five domains of policy and system stewardship, organisational leadership, clinical and academic leadership, operational leadership and emerging leaders. The network will have representation across disciplines, levels of experience and geographies; be outwards-facing, forward-thinking, open and collaborative; foster a culture of creativity, continuous improvement and innovation; and support members to participate in learning, training and mentorship opportunities. The network will aim to support attraction and retention of the mental health workforce through network-led improvements in culture and practice. It will also seek to provide the workforce with the support required to implement and drive reform in the sector; and provide better care to consumers through innovation, evidence-based change and culture of consumer-centred care. The concept will be co-designed with key stakeholders and seek to build on the existing Mental Health Inter-professional Leadership Network within a framework of improving the mental health workforce for reform. The vision of the RCVMHS to underpin this network with an intensive leadership training program, with ongoing learning and development experiences including training, networking, cross sectoral engagement, mentorship, and conferences will be at the heart of the work being undertaken.

66. The relationship with the Victorian Collaborative Centre for Mental Health and Wellbeing presents a key opportunity to link research, evaluation, innovation, translation and leadership. An interdisciplinary Mental Health Leadership Faculty combining the Centre for Mental Health Learning and the Victorian Collaborative Centre for Mental Health and Wellbeing could well provide the requisite support for leadership development at the level of Victoria's mental health system. Given that organisational readiness enables change and leadership drives it, embedding a leadership development capability within the Collaborative Centre will enhance its ability to develop the human resources required to lead and implement reform in the mental health sector.

LOCAL, NATIONAL OR INTERNATIONAL EXAMPLES WHERE EFFECTIVE LEADERSHIP HAS DRIVEN REFORM ON AN ENDURING BASIS

67. Not all healthcare reform is enduring. When healthcare reform cannot be sustained, I am reminded that change involves multiple elements of a system. The work of leadership is intentional and dynamic and must act to align those elements. Braithwaite et al (2017) explored this relationship between leadership and reform in a review of successful case studies drawn from the health systems of 60 countries.[37] None explicitly involved mental health reform. Several messages emerge, that are worthy of reflection.

a) Reform is relational and purpose driven.

i. An involvement and/or focus on patients and their needs creates a purpose and a momentum for change that can overcome substantial political and social barriers along the way. The most crucial question to

[37] Braithwaite J et al. 'Accomplishing reform: successful case studies drawn from the health systems of 60 countries', *International Journal for Quality in Health Care*, 29(6) (2017), 1-7.

answer in relation to reform is this: does the change make care better for the patient? ('Patient as the pre-eminent player' reform principle)

ii. It needs the leadership of individuals who inspire others to follow and/or a critical mass of people who embrace change. And for this reason, organisational culture is important. When organisational culture embraces change, individuals and groups of skilled, proactive participants emerge and are sufficiently supported to engage, and drive or simply embrace the implementation of the targeted change.

iii. It requires the engagement of stakeholders through effective communication and collaboration. In many ways, information including data underpins effective communication, so that technology and transparency are key enablers. It is through sharing and collaboration that data and information is transformed into intelligence. ('Data-to-information-to-intelligence' principle of reform)

b) Reform must be accountable. Transparency and partnerships are crucial in this regard. Governance and leadership must be carefully managed. Implementation must be based on clear principles of reform design, the engagement of stakeholders and the consistent use of evidence. ('Many hands' principle of reform)

c) Funding gets the ball rolling. Some level of seed funding, and in some instances a significant commitment of resources, was required. That said, examples of reform were not restricted to high-income countries alone.

d) Reform takes time. The most successful examples involved building momentum over time. There are three lessons that emerge from this observation. The first is that perseverance and political will were attributes of success, and reform was a journey not a destination. The second is that reform can start with small incremental or local initiatives that can and often

do lead to system-wide improvements. (The 'acorn-to-oak tree' principle of reform) The third is that the pace of change allows for improvement using data and client feedback, so that initiatives can change incrementally to accommodate new information, and more specifically, new intelligence which arises when information is interpreted by clinical experts, service users and communities.

68. I have outlined several examples of successful local changes in my 2019 witness statement. I would refer the reader to paragraphs 103-109, 126, 127, 130, and 133 . These concern initiatives at Alfred Health involving headspace and youth mental health; implementation of a behaviours of concern protocol to drive down the use of restrictive interventions; development and implementation of a mental health and addiction hub in the emergency department to manage increases in emergency mental health and substance-related demand; and expansion of consultation-liaison psychiatry services to the general acute and sub-acute hospitals through engagement with the management of occupational violence. These initiatives illustrate a number of the principles outlined by Braithwaite et al[38] including the importance of a primary focus on patient and family needs in ensuring sustained effort; the importance of leadership and organisational culture in building momentum for change; the use of data to drive learning and improvement; the pivotal value of funding in getting reform started; and the time it takes to embed reform through a process of design, prototyping, testing and improvement.

69. At a national level, the headspace centres[39] and Youth Early Psychosis Program represent the most visible development in the reform of mental health care for

[38] Braithwaite J et al. Op cit.

[39] McGorry P et al. 'headspace: Australia's National Youth Mental Health Foundation- where young minds come first', *Medical Journal of Australia*, 187(7) (2007), S68–S70.

young people.[40] Evaluating headspace at a national level has been difficult given the way in which the model has been implemented. Both the primary centres and the youth early psychosis programs have been commissioned through a mix of non-government and clinical organisations. There are differences in the technical expertise and cultures of those organisations, and this makes interpretation of findings difficult. A 2009 evaluation showed gaps in implementation of the model, with only a third of services covering all four of the model elements. Many had experienced difficulties attracting MBS-funded general practitioners and psychiatrists. Effective clinical governance, alternative sources of funding, workforce and high demand all contributed to sustainability.[41] A 2015 evaluation showed that the service had been especially successful in engaging vulnerable young clients,[42] with high levels of psychological distress and a range of social, emotional and health problems. Results showed small improvements in the mental health of headspace clients relative to two matched control groups. The strongest economic benefits arise from a significant reduction in the number of days lost due to illness, and a reduction in suicidal ideation and self-harm. The reform of youth mental health again illustrates many of the elements of success highlighted by Braithwaite et al.[43] There has been a relentless focus on patients and their needs; the leadership of a critical mass of advocates has been unquestionably effective; the engagement of stakeholders is evident in the range of organisations participating in the national and State-based reforms; funding has been pivotal; and the reform effort has been persistent over time, with considerable political will

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[40] McGorry P., 'The specialist youth mental health model: strengthening the weakest link in the public mental health system', *Medical Journal of Australia*, 187(7) (2007), S53-S56.

[41] Muir K et al. 'Headspace Evaluation Report. Independent Evaluation Of Headspace: The National Youth Mental Health Foundation', *Social Policy Research Centre* UNSW (2009).

[42] Hilferty, F., et al (2015). Is Headspace making a difference to young people's lives? Final Report of the independent evaluation of the headspace program. (SPRC Report 08/2015). Sydney: Social Policy Research Centre, UNSW Australia.

[43] Braithwaite J et al. Op cit.

standing behind initially small initiatives that over time grew into system-wide change.[44] Data and evaluation has been used to build on and improve a model[45] that has extended to several countries across the world.[46] Reform is not about short-term effort and certainly not a task for the faint hearted!

70. Finally, at an international level, the Recovery College movement also serves as an example of a successful mental health reform.[47] The first recovery colleges emerged in the USA in the 1990s. The movement is strongest in the UK, where the first recovery college opened in 2009.[48] Recovery colleges now exist in over 20 countries, including Australia and are supported by an international recovery college community of practice to promote research, knowledge exchange and understanding. Recovery colleges have several core components. The initiative uses an adult education model and not a clinical or therapeutic one. Participants register for classes, are provided with a curriculum of activities which they tailor to meet their own specific needs. The subject matter may be health-related (using medication, diagnosis, self-care, physical health, human rights) or focused on life skills, employment, or information technology. Peers are involved in every aspect of the recovery college including as faculty, in the design and delivery of courses, in governance and management, and as participants. Funding is derived from

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[44] Rickwood D et al., 'Australia's innovation in youth mental health care: The headspace centre model', *Early Intervention in Psychiatry* 13(1) (2019), 159–166.

[45] Rickwood D et al., 'Changes in psychological distress and psychosocial functioning in young people accessing headspace centres for mental health problems, *Medical Journal of Australia,* 202 (10) (2015), 537-543.

[46] Malla A et al. 'From early intervention in psychosis to youth mental health reform: a review of the evolution and transformation of mental health services for young people' *Social Psychiatry and Psychiatric Epidemiology* 51 (2016):319–326.

[47] Whitley R, Shepherd G and Slade M. 'Recovery colleges as a mental health innovation' *World Psychiatry* 18 (2) (2019), 141-42.

[48] Mary O'Hara, The Guardian 'It's given me hope": the rapid growth of mental health recovery colleges'. 14 May 2019 < https://www.theguardian.com/society/2019/may/14/mental-health-recovery-colleges .>

government health, employment and education streams, philanthropy and non-government sources. They are in health and mental health services, educational facilities and on-line. Alfred Health developed its own version of the recovery college in partnership with headspace and called it the headspace Discovery College[49]. Using an adult education model, the Discovery College is peer run. Courses are co-produced and co-delivered and bring together people with lived experience of mental illness, family members, interested members of the community and clinicians to develop skills, share knowledge and experience in relation to health and wellbeing and support individual recovery. The Discovery College has been extended into the adult service and pilot courses were set up in 2020. Course topics in 2020 include mindfulness, 'What is it about medication?", "Understanding self-harm" and "What is diagnosis?". Again, the reform reveals elements described by Braithwaite et al.[50] It is purpose driven and linked to the recovery movement in mental health; there has been a clear focus on the needs of consumers; leadership has provided momentum and energy; stakeholder engagement has been facilitated through effective communication and participation; frequently small amounts of funding have been effective in seeding the model (this was certainly the case at Alfred Health); and the reform has evolved incrementally from small beginnings into an international movement through perseverance and the impact of evaluation and improvement.[51] [52]

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[49] Hopkins L, Foser A and Nitikin L. 'The process of establishing Discovery College in Melbourne' *Mental Health and Social Inclusion* 22 (4) (2018), 187-194 < https://doi.org/10.1108/MHSI-07-2018-0023 >.

[50] Braithwaite J et al. Op cit.

[51] Sommer, J, Gill, K. and Stein-Parbury, J, 'Walking side-by-side: Recovery Colleges revolutionising mental health care', *Mental Health and Social Inclusion*, 22 (1) (2018), 18-26 < https://doi.org/10.1108/MHSI-11-2017-0050 >,

[52] Hopkins L, Pedwell G and Lee S. 'Educational outcomes of Discovery College participation for young people', *Mental Health and Social Inclusion* 22 (4) (2018), 195-202 <https://doi.org/10.1108/MHSI-07-2018-0024>.

SUPPORTING THE DELIVERY OF REFORM THROUGH LEADERSHIP AND PARTNERSHIP BETWEEN DIVERSE STAKEHOLDERS IN THE MENTAL HEALTH SECTOR

71. I believe that the development of leadership and partnership between diverse stakeholders in the mental health sector can be facilitated through access to formal leadership development programmes for emerging leaders in the sector. The current situation with respect to structured management and leadership education is mixed. I benefited greatly from the academic programs at Monash University and La Trobe University where I completed a Graduate Diploma in Health Services Management and a Master of Health Administration respectively. Equally valuable were the Williamson Fellowship I undertook at Leadership Victoria and the executive global health leadership programme I undertook at the University of London. A key feature of these programmes was the multi-disciplinary backgrounds of the people with whom I engaged in these programmes, many of whom were already in positions of leadership. Another critical factor was the capacity to rapidly apply the taught material and the formal assessments (where applicable) to challenges being met in the workplace at the time. The fact that the programmes were not specific to mental health did not limit their utility for me.

72. Senior and junior doctors employed in public health services are entitled to financial support of continuing medical education (the CME allowance) together with conference/study leave.[53] Industrial awards for nursing and allied health practitioners also entitle them to paid professional development leave and additional study leave where a component of the course is relevant to the work of the employee. There is no data to the best of my knowledge indicating how this leave is used and what proportion of it is taken for the purpose of leadership and

[53] Department of Health and Human Services, 2006 Public Health Medical Workforce EBA - Guidelines and Process for Reimbursement Funding for CME Support and Sabbatical Leave Backfill Premium Costs, November 2006 <https://www2.health.vic.gov.au/about/news-and-events/hospitalcirculars/circ2406 >.

management training. An approach co-ordinated at the level of the Victorian government might seek to collect data to determine the extent of leadership and management training of medical, nursing and allied health staff. Guidance could also be provided to health services and individual practitioners to map out potentially useful options for training and professional development and ensure consistency of practice across the health system with respect to approval of activities.

73. The Mental Health and Drugs branch in DHHS has, through the Chief Nursing Officer, undertaken several initiatives that I would like to note and commend. The Victorian Mental Health Inter-professional Leadership Network (**VMHILN**) is a flagship leadership initiative funded by the Victorian DHHS. It began in 2015 and provides a community of practice that draws together nursing, allied health, medical and lived experience workers.[54] The Centre for Mental Health Learning (**CMHL**) brings together mental health peer workers and clinicians into a central agency for public mental health workforce development in Victoria. The Centre for Psychiatric Nursing is based at the University of Melbourne School of Health Sciences and is funded to advance the practice of mental health nursing through research, education, engagement and consultation. All these initiatives represent important contributions to evaluation, innovation and learning and in this way to the development of individual leadership capacity within the system. Their influence, though, is limited by four factors. First, there is no coordinated approach to the development of leadership capability in the sector. Second, funding and therefore impact is small. Third, only the VMHILN addresses leadership development as its core purpose. Finally, neither it nor the CMHL engage doctors successfully and the Royal Australian and New Zealand College of Psychiatrists is conspicuous by its absence in this interdisciplinary space.

[54] Victorian Mental Health Interprofessional Leadership Network, 'Leading Change for recovery' <https://www.vmhiln.org.au/> [accessed 11 August 2020].

74. The National Mental Health Commission has developed the Australian National Mental Health Fellowship, which is funded by the Commonwealth Government. The program was designed by the University of Melbourne, and is made up of an educational component, experiential learning, reflective practice and group activity supported by expert facilitators, coaches and mentors. The design of the program has incorporated inputs from several perspectives, including business and economics, population and global health, and from the National Mental Health Commission and its Advisory Group. Content is delivered by academics, managers, health service leaders and industry partners such as the Australasian College of Health Services Management.[55] I am not aware of any evaluations of this project, but I sponsored the successful application of a colleague from the lived experience workforce at Alfred Health and can attest to the positive impact on her professional and leadership development.

75. I have already outlined the work being undertaken by MHRV to implement the recommendation of the Royal Commission with respect to developing a mental health leadership network. Earlier in this statement, I recommended creating a Mental Health Leadership Faculty within the Victorian Collaborative Centre in order to establish a leadership framework that will embed a culture of collaborative leadership in the Victorian mental health sector. Such a framework should actively seek to engage emerging and established leaders in the clinical and non-clinical sectors, by offering quality programs, mentoring and network opportunities. Leadership development must always seek to be creative, innovative and brave through connections that are diverse and that challenge established orthodoxy. Therefore, inter-disciplinary connections should be cultivated with professional colleges serving the mental healthcare workforce, such as the RANZCP and the Royal College of Mental Health Nursing (**RCMHN**). Inter-sectoral connections should be established with other healthcare, community and corporate leadership

[55] University of Melbourne, 'Creating leaders in mental health', <https://unimelb.edu.au/professional-development/staff-training/case-studies/national-mental-health-commission> [accessed 11 August 2020].

organisations. Program development should consider issues and networks specific to the mental health sector and broader leadership issues in partnership with organisations such as the National Mental Health Commission, universities and non-profit leadership organisations across Australia.

Royal Commission into
Victoria's Mental Health System

DETERMINANTS OF GOOD MENTAL HEALTH AND WORKING WITH COMMUNITIES TO ACHIEVE GOOD OUTCOMES

76. The World Health Organisation defines the social determinants of health as the conditions in which people "are born, grow, live, work and age". Because these are shaped by the ways in which wealth, power and resources are distributed, solutions are very much linked to the choices made by governments and communities about equity, justice and ensuring access to housing, education and healthcare.

77. Social determinants have long been known to contribute to mental illness, as predisposing, precipitating, perpetuating and protective factors. This understanding is the basis of several fields of study in psychiatry including social psychiatry, public mental health, global mental health and transcultural psychiatry. It is also implicit in the dominant biopsychosocial model taught in Australian psychiatry, which holds that the causes and treatments of mental illness can only be understood as an outcome of the interaction of biological, psychological, and social factors.[56] The importance of social determinants is reflected in the observation that consumers of Victoria's mental health system and their families continue to experience severe social disadvantage.

78. In many ways, the narrative of a broken system has drawn attention to how mental healthcare is delivered and away from an approach to public mental health focused on the social determinants of health that can prevent mental illness or mitigate its impact. The Victorian government has invested substantially in an approach to public mental health policy development that has emphasised the importance of the social determinants upon mental health and emotional wellbeing. The Victorian

[56] The Royal Australasian & New Zealand College of Psychiatrists 'The role of the psychiatrist in Australia and New Zealand' <https://bit.ly/2BwCGXc>.

Ten-Year Mental Health Plan published in 2015[57] and the Fifth National Mental Health and Suicide Prevention Plan 2017[58] are the most recent State and Commonwealth mental health plans. Focus areas outlined in the State plan have included the promotion of good mental health and wellbeing, the prevention of mental illness, and access to treatment and recovery for people with mental illness. The public mental health agenda in Victoria was further expanded with development of the Victorian suicide prevention framework 2016-2025,[59] the Balit Murrup Aboriginal social and emotional well-being framework 2017-27,[60] the Victorian mental health workforce strategy,[61] all of which preceded the establishment of the Royal Commission in 2018. This should be augmented by a reporting framework that addresses whole of government efforts in several key domains of activity with profound impact on the mental health and wellbeing of the population, including:

a) The promotion of positive mental health, through programs that build mental capital and wellbeing, and through community development, urban design and regeneration; and

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[57] Department of Health and Human Services, Victoria's 10-year mental health plan, November 2015. https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-plan

[58] National Mental Health Commission, 'Fifth National Mental health and Suicide Prevention Plan' <https://www.mentalhealthcommission.gov.au/Monitoring-and-Reporting/Fifth-Plan/5th-National-Mental-Health-and-Suicide-Prevention> [accessed 11 August 2020].

[59] Department of Health and Human Services, Victorian suicide prevention framework 2016-2025, July 2016.

[60] Department of Health and Human Services, Balit Murrup Aboriginal social and emotional wellbeing framework 2017-2027, 2017 <https://www.dhhs.vic.gov.au/sites/default/files/documents/201710/Balit-Murrup-Aboriginal-social-and-emotional-wellbeing-framework-2017-2027.pdf >.

[61] Department of Health and Human Services, Mental Health Workforce Strategy, July 2016 < https://www2.health.vic.gov.au/about/publications/policiesandguidelines/mental-health-workforce-strategy>.

b) The prevention of mental illness through programs designed to mitigate or eliminate the incidence or consequences of stigma and inequality; trauma related to family violence, community violence, road traffic accidents, workplace incidents, bullying and harassment; disasters and emergencies, including bushfires and pandemics; substance misuse, due to prescribed and illicit drugs; problem gambling; social isolation and loneliness; homelessness; and suicide and self-harm.

79. **Work is needed to identify indicators, although there is existing data and literature, which will guide the process.** As an example, a paper previously cited by Rosenberg et al recommended that social domain indicators for mental illness could include the proportion of people with a mental illness reporting they have stable housing; participation rates by people with a mental illness of working age in employment; participation rates by people with mental illness aged 16-30 years in education and training; and community surveys of attitudes towards mental illness.[62] The National Mental Health Commission also proposed a monitoring and reporting framework made up of outcomes in three domains, namely social, system and individual/population mental health and wellbeing. To that can be added indicators of social isolation, suicide and self-harm, substance misuse and exposure to and outcomes of trauma.

80. I would like to focus on two key priorities for intervention.

HOUSING and HOMELESSNESS

81. Access to shelter is a human right. A high-income country like Australia should aspire to ensuring all its citizens have access to a home. Homeless people with serious and persistent mental illness need the support of an integrated wrap-around

[62] Rosenberg S, Hickie I, McGorry P et al. 'Using accountability for mental health to drive reform' *The Medical Journal of Australia* 203 (8) (2015), 328-330.

system of health and social services built on a foundation of appropriate housing. It is only when suitable housing is available that a reduction in the cost of preventable healthcare for people experiencing homelessness can be achieved.

82. The Burdekin Report asserted that:

> *"The policy of deinstitutionalising psychiatric patients, (or not hospitalising them in the first place) was conceived in the belief that most people with mental illness would be better off living and being treated in the community. It assumes they will have somewhere to live – an assumption which is frequently unfounded. Mentally ill people have great difficulty finding and keeping accommodation – poverty, discrimination and the nature of the disability… Unsuitable accommodation (or none at all) can erode or destroy the benefits of treatment and rehabilitation received in hospital."* [63]

83. In a similar vein, I wrote in my 2019 witness statement that I believed that Victoria's mental health system is inadequately supported to ensure that that no person is discharged from care into homelessness. That situation had not changed until the onset of the COVID-19 pandemic in March 2020. The most pressing need is the provision of affordable housing for the Victorian community. The policy levers by which this is to be achieved are beyond my expertise, but it would seem self-evident that the construction of social housing is a first step. This could be undertaken by the Victorian government directly or encouraged by incentivisation of the for-purpose sector.

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[63] Burdekin B 'Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness', Page 340, Volume 1. Human Rights and Equal Opportunity Commission, Australian Government Publishing Service, Canberra (1993).

84. The Victorian government response to the COVID-19 pandemic has included the provision of temporary accommodation for people experiencing homelessness.[64] Since the state of emergency was declared, there has been additional funding to support the sector. The number of people assisted, including male rough sleepers, into emergency accommodation and with private rental brokerage has increased. It is much too early to tell what health and social impact this program of assistance will have but it is evident that it does present a unique opportunity to work with a group of clients who are notoriously difficult to engage and for whom substantial gains in health and mental health can be made with the right assistance. Steps are being taken to ensure this occurs in a co-ordinated and structured manner with key health services being engaged to work with housing providers. It is possible that the economic downturn being anticipated at least in the short term will facilitate access to more affordable housing options. In these difficult circumstances, opportunities may open for governments to explore options to support vulnerable groups of people, including the mentally ill, to access housing.

85. **One program which the Royal Commission should consider as a community model and with which it would be familiar is Doorway**, an integrated housing and recovery support program, for people with a severe and persistent mental illness receiving care in the public mental health system in Victoria. An iteration of the **Housing First model in Victoria**, participants source and choose properties in the open rental market, and receive rental subsidies, advocacy and brokerage support through a housing and recovery worker employed within the program. In a study being submitted for publication of which I am a co-author (David Dunt is the first author), 157 participants were accepted into the program and of these, 57% were subsequently housed. Outcomes were compared to a group of 80 participants with the same ability criteria who formed the control population. Results showed that participants of the program achieved an extra 119.4 days at a cost of A$168

[64] Maggie Coggan,Probono Australia. 'Victorian rough sleepers given coronavirus lifeline', 15 April 2020 < https://probonoaustralia.com.au/news/2020/04/victorian-rough-sleepers-given-coronavirus-lifeline/>.

per day per additional enrolled participant, along with substantial quality-of-life advantages.

86. Steps should be taken towards developing integrated homeless health services in inner Melbourne, targeting people experiencing primary and secondary homelessness. Specialist psychiatric services for homeless people are currently provided by three mental health services in the inner metropolitan region - St Vincent's Health, Melbourne Health and Alfred Health. Primary healthcare and social services, including housing, are provided separately. This model is problematic for two reasons. First, homeless people in the inner metropolitan region are typically mobile and move between catchments. In the current system, this is a cause of discontinuities in care. Second, the provision of psychiatric services in isolation to a group of clients with complex health and social needs is not ideal. Integrated homeless services should combine mental and addiction health, primary health, and housing within a single platform. Elements of the model should include a single point of intake, co-location and an activity-based funding model to encourage prevention, integration and continuity of care.

87. There is also an opportunity to consider utilising emergency department contact as a platform for entry into a service pathway that leads to an integrated homeless health response. A study undertaken at The Alfred approached 1208 consecutive patients presenting in a single week to the ED, and prospectively screened 504 who chose to participate. Of these, 7.9% were homeless, compared to 0.8% of ED presentations coded as homeless in the Victorian Emergency Minimum Dataset and 2.3% of the 704 non-screened patients identified as homeless using Victorian Emergency Minimum Dataset Usual Accommodation. Within the screened sample, homeless patients were more likely to be male, arrive by emergency ambulance/with police, have a psychosocial diagnosis, and be frequent presenters. Re-presentation within 28 days occurred for 43% of homeless and 15% of not-

homeless patients.[65] Better identification of homeless status in the emergency department could allow for entry into care pathways that integrate mental, addiction and physical healthcare and social and housing support and act to reduce future emergency presentations through prevention and early intervention. In high needs areas, these could be co-located at sites managed by community health services that provide primary care.

LONELINESS AND SOCIAL CONNECTION

88. Loneliness and social isolation have long been a subject of interest to mental health researchers. The appointment of Tracey Crouch as Minister for Loneliness in the UK in 2018, however, prompted an upsurge in interest in programmes aimed at tackling what has been referred to as a "growing problem" and a "public health epidemic".[66] Following the emergence of COVID-19 in 2020, the requirement for physical distancing and the consequent economic disruption has only amplified concerns about the impact of social isolation and interest in drawing upon community resources to mitigate its impact.

89. **So, what is loneliness and why does it matter?** Emerging from the discrepancy between desired and actual social relationships, loneliness is a multifaceted and subjective experience. It is linked to perceived but not necessarily actual social isolation.[67] It is a fundamentally aversive experience, unlike solitude, which can be both sought after and welcomed. As a signal to motivate behaviour change and re-establish social connections, loneliness can have both purpose and utility. But what

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[65] Lee S et al. 'Homeless status documentation at a metropolitan hospital emergency department' *Emergency Medicine Australasia* 31 (4) (2019), 639-645.

[66] Cacioppo JT and Cacioppo S. 'The growing problem of loneliness' *The Lancet* 391 (10119) (2018), 426.

[67] Hawkley L and Cacioppo JT. 'Loneliness matters. A theoretical and empirical review of consequences and mechanisms' *Annals of Behavioural Medicine* 40 (2) (2010), 218-27.

if loneliness becomes long-standing and pervasive, as is a reality for thousands of Victorians?

90. **It would be fair to say that the causes of loneliness are poorly understood, and that the risk factors identified are multifactorial and probably bi-directional.** In this way, loneliness appears more prevalent in people with depression, schizophrenia and social anxiety and with personality styles characterised by neurosis (or worry), introversion and conscientiousness. It is associated with maladaptive social cognitions and coping styles that are orientated towards emotions as opposed to problems. Heritable biological factors link a propensity to feel lonely and a susceptibility to some mental disorders.[68] And then there are links to the social determinants of health, as evidenced in studies showing associations between loneliness and high unemployment, poor access to healthcare, lower income, poor public transport and quality of residential neighbourhood including access to places that are green, active, pro-social and safe.[69]

91. **Longitudinal studies suggest that loneliness is itself associated with a range of physical and mental health consequences.**[70] Loneliness predicts increased mortality and morbidity, including physical health problems, such as hypertension, insomnia, obesity and coronary heart disease;[71] and increased mental health

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[68] Abdellaoui et al. 'Predicting loneliness with polygenic scores of social, psychological, and psychiatric traits', *Genes brain and behaviour*; 17(6) (2018), e12472.

[69] McCay L et al. 'Urban design and Mental Health', *Mental Health and Illness in the City* (2017), 1-24.

[70] Ong AD, Uchino BN and Wethington E. 'Loneliness and health in older adults: a mini-review and synthesis', *Gerontology* 62 (4) (2016), 443-449.

[71] Hawkley L, Cacioppo J. 'Loneliness matters: a theoretical and empirical review of consequences and mechanisms', *Annals of Behavioural Medicine*; 40(2) (2010), 218-227.

complications including depression, anxiety, suicidal thoughts,[72] obsessive-compulsive disorder, paranoia, impulsivity and aggression.[73] The proximal and latent consequences of loneliness themselves amplify the experience of loneliness, and so the cycle is reinforced and extended.

92. **Measuring loneliness is difficult.** There is no standardised measure used across studies and sampling methods differ substantially. Nevertheless, there are useful estimates of the prevalence of loneliness in our communities. Using data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey conducted between 2001-09, Baker (2012) found that about 9% of people experienced loneliness in any given year and that people living in lone person or lone parent households were twice as likely to experience loneliness as those living in couple households.[74] He also described important gender differences, with loneliness being more commonly reported in the survey period among men (36%) than women (29%), though this is not a consistent finding in other studies, in which loneliness is found to be more common in women (e.g. Meltzer et al, 2013). In a similar vein, the Australian Psychological Society's Australian Loneliness Report described an online survey of 1678 people, of whom 27.6% described feeling lonely three or more days a week, and this was associated with a worse health status and a higher likelihood of being depressed or anxious about social interaction.[75]

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[72] Beutel ME et al, 'Loneliness in the general population: prevalence, determinants and relations to mental health' *BMC Psychiatry* 17 (1) (2017), 97.

[73] Meltzer H et al. 'Feelings of loneliness among adults with mental disorder', *Social Psychiatry and Psychiatric Epidemiology*; 48 (1) (2013), 5-13.

[74] Baker D. 'All the lonely people: Loneliness in Australia, 2001-2009', *The Australia Institute* 9 (2012).

[75] Lim M, Australian Psychological Society, Australian Loneliness Report. A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing', 2017 < https://researchbank.swinburne.edu.au/file/c1d9cd16-ddbe-417f-bbc4-3d499e95bdec/1/2018-australian_loneliness_report.pdf >.

93. **The situation among people suffering from mental illness and their carers is most concerning**. The Australian National Survey of Psychosis studied 1825 people with schizophrenia and found that over 80% reported feeling lonely and described loneliness as one of the top three barriers to recovery, together with poverty and unemployment.[76] While loneliness is not an inevitable consequence of the experience of being a carer,[77] caring can restrict the social networks of informal caregivers,[78] lead to higher self-alienation[79] and "affiliate stigma",[80] and be associated with loneliness in women, and in people with poor physical health, and/or low educational attainment. Experiences of loneliness among people with mental ill-health were described by Lindgren et al (2014) as "looking at the world through a frosted window."[81]

94. So, how should the mental health system respond?

a) **There are individual and group treatments, of course that could be delivered by clinicians, counsellors and peer workers**. The most effective

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[76] Morgan VA et al. 'Responding to challenges for people with psychotic illness: updated evidence from the Survey of High Impact Psychosis', *Australia New Zealand Journal of Psychiatry* 51 (2) (2017), 124-40.

[77] Ekwall AK et al. 'Loneliness is a predictor of quality-of-life among older caregivers', *Journal of Advanced Nursing* 49 (1) (2005), 23-32.

[78] Vasileiou et al 'Experiences of loneliness associated with being an informal caregiver: a qualitative investigation supplementary paper' *Frontiers in Psychology* 8 (2017), 585.

[79] Rokach A et al. 'The loneliness experience of the dying and those who care for them' Palliative and Support Care 5 (2) (2007), 153-159.

[80] Mak W and Cheung R. 'Affiliate stigma among caregivers of people with intellectual disability or mental illness' *Journal of Applied Research in Intellectual Disability* 21(6) 2008, 532-545.

[81] Lindgren B et al. 'Looking at the world through a frosted window: experiences of loneliness among persons with mental ill-health', *Journal and Psychiatric and Mental Health Nursing* 21 (2) (2014), 114-120.

are the cognitive therapies, which address social maladaptive cognitions.[82] Many other therapies intended to help individuals experiencing chronic loneliness have been studied, including an on-line adaptation of a Friendship Enrichment Program[83] and interventions to create opportunities to meet others, to increase social support and to teach social skills. But their effectiveness is limited, as loneliness is mediated by the quality of contacts and not just the quantity; because meaningful relationships depend on mutuality and not merely support; and because gains are typically short-lived and do not generalize beyond the setting of the intervention. Also lacking are psychosocial interventions that specifically target loneliness in psychosis, and that account for additional barriers such as social skills deficits, impoverished social networks and negative symptoms.[84]

b) **Health services can play a critical role in enhancing social connections**. The mental health system in Trieste, Italy is a lead World Health Organisation Collaborating Centre for Service Development and has adopted a bold strategy of de-emphasising hierarchical power and hospital care in favour of community care and facilitating the rights of citizenship including social relationships and inclusion for people with serious mental illness. The Trieste model demonstrates that tackling loneliness and social exclusion depends on community ownership and acceptance and financial and legislative support from local and regional government. To be clear, I think that barriers exist to adopting a similar model here in Victoria. These include the fragmentation of Commonwealth and State responsibilities, healthcare models that do not

[82] Cacioppo S et al. 'Loneliness: clinical import and interventions' *Perspectives on Psychological Science* 10 (2) (2015), 238-249.

[83] Bouwman T et al. 'Does stimulating various coping strategies alleviate loneliness? Results from an online friendship enrichment program', *Journal of Social and Personal Relationships* 34 (6) (2017), 739-811.

[84] Lim M et al. 'Loneliness and psychosis: a systematic review', *Social Psychiatry and Psychiatric Epidemiology* 53 (3) (2018), 221-238.

integrate clinical and psychosocial services, funding models that are independent of activity and outcomes; as well as fear and stigma.

c) **Local and State governments, universities and NGOs can also contribute.** A number of organisations, including Swinburne University, the University of Western Australia, Relationships Australia and UnitingCare, are collaborating in the Australian Coalition to End Loneliness/**End Loneliness Together** initiative to build an evidence-based approach to ending loneliness across all life stages.[85] VicHealth, Victoria's health promotion foundation has identified positive social connection among young people as an objective in its **Action Agenda for Health Promotion 2019-2023.**[86]

d) There are other pathways to change focused on developing place-based initiatives. Place-based approaches respond to complex, intersecting local drivers that require a cross-portfolio and sectoral response. They develop a shared understanding of the local context and draw from a broad range of evidence including data, research, and lived experience. They reflect locally agreed priorities and embed deep engagement and collaborative governance structures that engage across sectors and with a diverse cross-section of the community.[87]

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[85] Ending loneliness together, <https://www.endloneliness.com.au/> [accessed 11 August 2020].

[86] VicHealth, Action Agenda for Health Promotion 2019-2023 <https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/Action-Agenda/Action-Agenda-2019_2023.pdf?la=enandhash=3D4EBE628C6952A6026592A97962A3058C7C3FDB> [accessed 11 August 2020].

[87] Victorian Government, 'A framework for place-based approaches The start of a conversation about working differently for better outcomes' <https://www.vic.gov.au/framework-place-based-approaches/place> [accessed 11 August 2020].

e) The **Inner South East Metropolitan Partnership** in Melbourne (**ISEMP**), of which I am a community member, is a State government initiative in Victoria that brings together community and business members and representatives of State and local government to advise State government on what matters in their region.[88] Citizen assemblies held in 2017 and 2018 identified connectedness, inclusion and social interaction as key concerns. In 2018, the ISEMP worked with a social design consulting group to consult with content experts and community members to identify gaps and areas of duplication and to highlight opportunities for future policy initiatives and spending decisions by government in the region. The resultant report was published in 2019.[89] Three cohorts were the focus of attention, including young people transitioning out of school, young women transitioning into parenthood, and older people transitioning into retirement. Several common themes emerged in the construction of journey maps depicting the progression of these cohorts in and out of social isolation. **Life transitions** were identified as giving rise to high risk of social isolation, as was assuming a carer role and problems with physical and mental health. When it came to overcome social isolation and loneliness, **poverty** was a barrier to accessing **public transport and community resources**, and by extension social connection. An assets map was constructed based on an Asset-Based Community Development (**ABCD**) approach used by the UK Campaign to End Loneliness. The approach holds

[88] Department of Jobs, Precincts and Regions, 'Inner South-east Metropolitan Partnership' <https://www.suburbandevelopment.vic.gov.au/partnerships/metropolitan-partnerships/inner-south-east-partnership> [accessed 11 August 2020].

[89] Inner South-East Metropolitan Partnership, Social isolation and loneliness Project Report 2019 Prepared by Clear Horizon for the Inner South-East Metropolitan Partnership Working Group, 2019. <https://bit.ly/2Xw8Quv>.

that every community has a supply of resources that can be used to build the community, solve problems, and sustain health and wellbeing.[90]

f) **The ISEMP is continuing to progress and refine its work on loneliness.** Funding from the Metropolitan Partnerships Development Fund (**MPDF**) is being made available to the Social Innovation Research Institute at Swinburne University to undertake a project to **develop a regional place-based approach to social inclusion, identify possible initiatives and construct an evaluation framework**. An alliance will create a community of practice to include metropolitan partnership members, local governments, the Australian Red Cross, Swinburne University and key service providers, including health and mental health service providers. The project will engage community and co-design in the establishment of the alliance and will seek to identify policy settings that impact on social connectedness in discrete local communities and local issues. Inquiry into the impact of the design of local and digital places on social connection will be included. Local short, medium and long-term initiatives will be considered in light of the impact of the coronavirus pandemic. The outcome framework will include indicators that can support place-based evaluation of regional outcome measures. The final recommendations of the project will propose ideas to support discrete local areas establish and maintain collaborative networks, which will then be subject to future project work and iteration. The ambition is that such networks will improve community connectedness and community participation; share and communicate data to inform local decision-making; and illustrate how to adequately link a key community stakeholders and government decision-makers.

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[90] Campaign to End Loneliness: Connections in Older Age, 'Loneliness and Social Isolation: Guidance for Local Authorities and Commissioners'<https://campaigntoendloneliness.org/guidance/structural-enablers/> [accessed 11 August 2020].

95. **Loneliness is a public health issue with consequences for quality of life, health and service utilisation**. It is also a central experience for many people with severe mental illness and their families. Solutions to loneliness in the mentally ill remain a challenge. They must be co-designed to include peer-led, social, and clinical approaches. They could be embedded in the experience and design of places, communities and services and link together local assets such as volunteers, social circles, under-used buildings and land, options for public transport, and access to public spaces. More research is required at the level of the individual and family, where an interdisciplinary approach that connects people with lived experience, to experts in a range of sectors including mental health, service design, urban planning and community development can help mobilise a response; and at a systems level, where the Victorian and local governments, universities and health services can play an important role in facilitating the development of networks of citizens and service providers to develop place-based solutions for social isolation.

3. SERVICE EXCELLENCE

CHALLENGES IN ACHIEVING CHANGE IN ORGANISATIONAL CULTURE

96. Variations exist in the social context (i.e. culture and climate) of health organisations. These may account for differences in the effectiveness of mental health services that provide care to similar populations with similarly trained clinicians. So, what is culture and what can be said about the culture of mental health services? Organisational culture describes how work is done. It is measured through the behavioural expectations reported by members of the organisation[91]. Culture, together with strategy and leadership, are the primary levers available to organisations to maintain viability and effectiveness. If strategy offers a formal logic for the goals of an organisation, then culture guides activity through shared assumptions and group norms. Where strategy is overt, the values and assumptions that underpin culture are typically implicit, even if they are shared, pervasive, and enduring.

97. **The availability, responsiveness and continuity of mental health services are in part functions of organisational culture and climate (OCC) and can be transformed by specifically designed interventions**[92]. A study by Glisson et al (2012) randomly assigned 26 community-based mental health programs for youth to an organisational intervention designed to impact OCC or a control group. Programs providing hospital and emergency care only or serving young people with severe developmental disabilities or psychosis were excluded. The study found that organisations subject to the active intervention were less rigid and had more engaged and functional organisational climates. Furthermore, they demonstrated

[91] It is often described in terms of layers, with the values or assumptions representing the inner layer and the behavioural expectations representing the outer layer.

[92] Glisson C. 'The organisational context of children's mental health services', Clinical Child and Family Psychology Review 5 (2002),233–53.

less role conflict and improved morale, job satisfaction and organisational commitment[93].

98. **Elements of the social context of organisations can be directly associated with consumer outcomes.** Findings from the National Confidential Inquiry into Suicide and Homicide found that higher suicide rates of registered clients are associated with characteristics of provider organisations, including higher non-medical staff turnover, patient complaints, patient safety incidents, use of compulsory orders, rates of psychotropic prescriptions and medical consultant and psychiatric nurse staffing, but not staff sickness, or staff or patient satisfaction[94]. A study of 2,380 youth and 1,740 frontline case workers in 73 child welfare systems, found that systems with more proficient and less resistant organisational cultures exhibited more functional, more engaged and less stressful climates, and these in turn exhibited superior youth outcomes[95]. Glisson et al analysed a group of programs serving only school-aged youth in the study cited in paragraph 4.2 and found that psychosocial outcomes for participating youth were significantly better in the programs that completed the 18-month intervention[96].

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[93] Glisson C et al. 'Randomized trial of the availability, responsiveness and continuity (ARC) organisational intervention with community-based mental health programs and clinicians serving youth', *Child and Adolescent Psychiatry* 51 (8) (2012), 780-787.

[94] Kapur N, Hunt IM, Ibrahim S, et al. 'Healthy services and safer patients: links between patient suicide and features of mental health care providers. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)', Manchester: University of Manchester, 2015.

[95] Williams NJ and Glisson C. 'Testing a theory of organisational culture, climate and youth outcomes in child welfare systems: A United States national study'. *Child Abuse Neglect* 38 (4) (2014), 757-767.

[96] Glisson C, Hemmelgarn A, Green P, Williams NJ. 'Randomized trial of the availability responsiveness and continuity (ARC) organisational intervention for improving youth outcomes in community mental health programs'. *Journal of American Academy of Child and Adolescent Psychiatry* 52 (5) (2013), 493–500.

99. **The social context of an organisation determines the diffusion of novel ideas, whether these involve evidence-based interventions or different ways of working with consumers, carers, and communities**. OCC shapes which ideas are adopted, and the extent to which they are implemented as intended or adapted and changed. The elements that contribute to a climate for implementation are typically cumulative and there is typically no one factor that represents the difference between success and failure. Thus, training clinicians and peer workers; motivating them through what is celebrated and rewarded; recruitment or promotion of healthcare workers skilled in innovation; shaping innovation to match the proficiency and expertise of healthcare workers; harnessing the support of health service executives and boards; and ensuring a fit of innovation and values may all contribute individually or collectively to successful outcomes.[97]

100. **In order to understand how organisations with cultures that produce poor patient outcomes change, I would like to draw attention to two models that rely upon an understanding of how people respond to each other and to change.**

a) The **Integrated Culture Framework** emerges from two dimensions that describe how people interact along a scale of [A] Independence to interdependence and [B] Flexibility to stability. This process reveals a structural framework with eight dominant styles that can be applied to both organisations and leaders [see diagram 1 below in paragraph 4.6][98]. These structures are relatively stable and are characterised by an orientation to [1] relationships and mutual trust (Caring); [2] idealism and altruism (Purpose); [3] exploration, expansiveness and creativity (Learning); [4] fun and excitement (Enjoyment); [5]

[97] Klein KJ and Sorra JS. 'The challenge of innovation implementation', *The Academy of Management Review* 21 (4) (1996), 1055-1080.

[98] Groysberg B, Lee J, Price J, Cheng JYJ. 'The leader's guide to corporate culture. How to manage the eight critical elements of organisational life', *Harvard Business Review* , January – February 2018, 44 – 53.

achievement and winning (Results); [6] strength, decisiveness and boldness (Authority); [7] planning, caution and preparedness (Planning); and [8] respect, structure and shared norms (Order). Proximal relationships are important as they indicate styles that will coexist more easily within organisations and people, combinations such as safety and order or learning and enjoyment. Styles that are further apart require far more organisational energy to develop and maintain simultaneously. Each style has its advantages and disadvantages, and each involves trade-offs.

b) In a similar vein, the **Adaptive Culture Framework** deems that in the face of constant change, both leaders and organisational cultures need to continually evolve and develop, and to create greater agility and adaptability for themselves, the people they lead, their clients and their communities. The model draws from the LDF of Torbert and associates, cited earlier in this statement. Just as leadership development in individuals can be conceived of as involving a series of stages from conventional to post-conventional action logics, so too can the development of organisational culture. **Once again, the idea of leadership as a property of individuals and organisations emerges**. The Adaptive Culture Framework (ACF) identifies stages of cultural evolution across two dimensions, concerned with:

i. [1] How people work together, and individuals grow and develop throughout the system (dependent – independent – interdependent – co-evolving);

ii. [2] What the organisation focuses on as being important and how this focus determines the capacity of the organisation to adapt in the face of change (compliance – results – capacity building – evolving systems).[99]

101. **The Adaptive Culture Framework is more dynamic**. Organisations may evolve through a series of stages, not unlike the Leadership Development Framework of Torbert and associates. Organisations that are compliant and achievement oriented, expect their people to be accountable and value stability, expertise and outcomes in an environment that is procedure-driven and competitive. Management tends to be hierarchical and results orientated. In contrast collaborative growth and co-creation cultures expect their people to be stakeholder oriented and strategic and to value purpose, insights and co-creation, in an environment that is inclusive, and oriented to future adaptation. Management tends to be empowering and even disruptive.

[99] Brown A, Cameron A, and Adaptive Cultures. Developing adaptive organisations through leadership and culture, 2018.

Royal Commission into
Victoria's Mental Health System

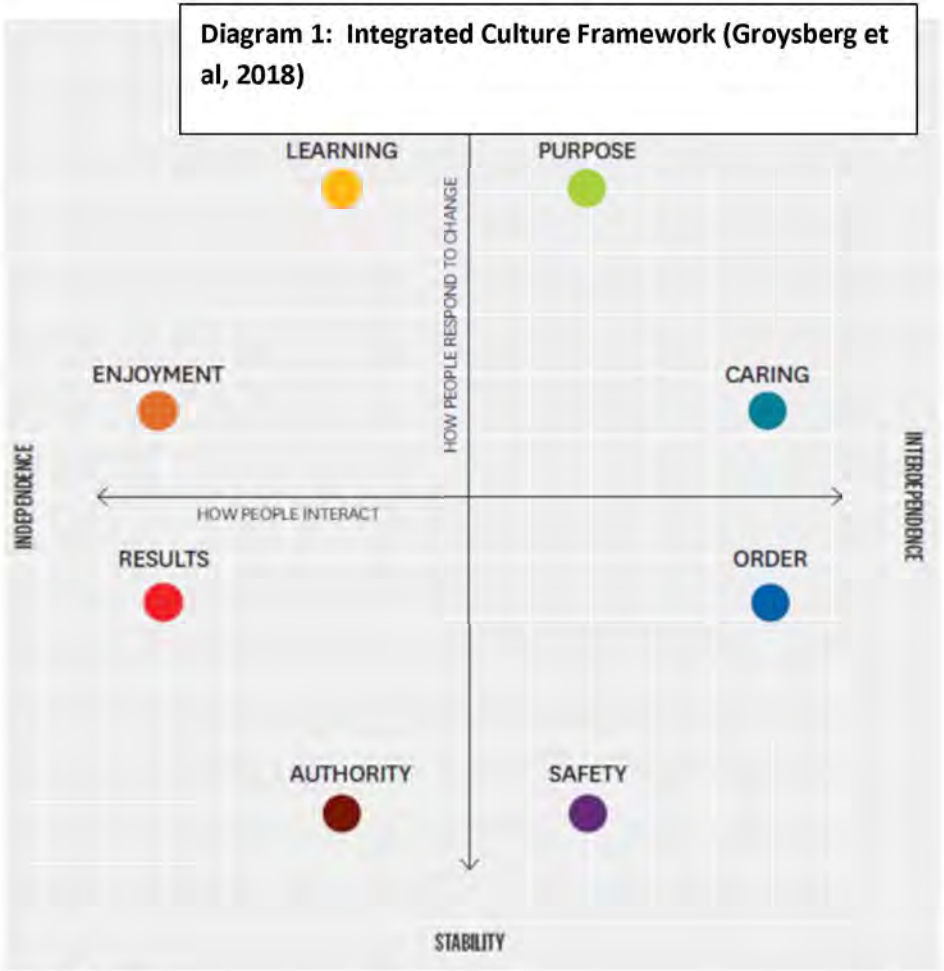

Diagram 1: Integrated Culture Framework (Groysberg et al, 2018)

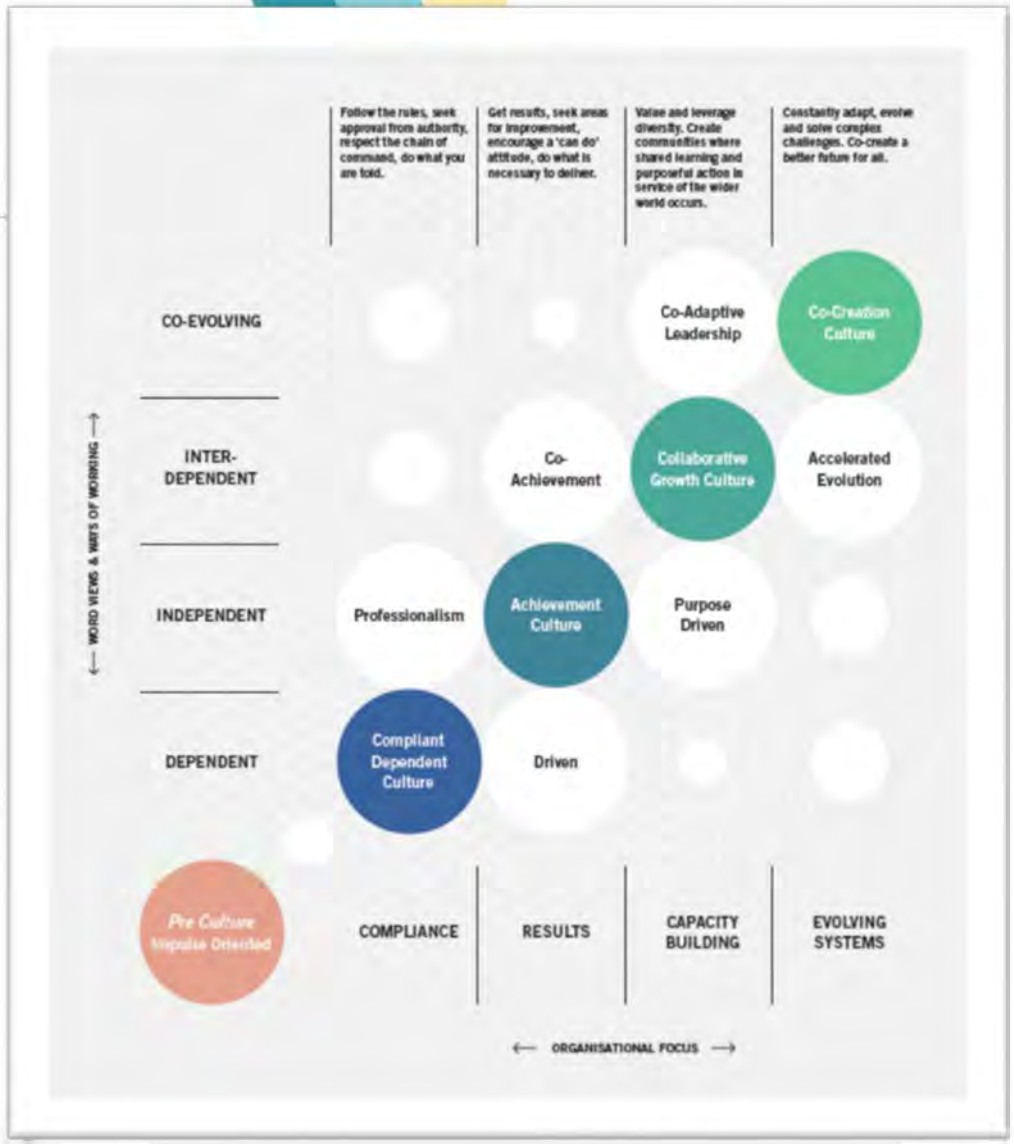

Diagram 2: Adaptive Culture Framework (Brown and Cameron, 2018

102. I would like to apply the adaptive culture framework model to what I have observed in mental health services in Victoria.

103. **Clinical mental health services have similar jobs to do right across the State**. They deliver mental healthcare to people suffering from mental illness or distress. Consumers of clinical MHS may find themselves at high and/or imminent risk of harm or of clinical deterioration and consequences may include self-neglect, self-injury, suicide, intoxication and withdrawal, and aggression towards others. Preventing and managing clinical deterioration is a key consideration for services. Some services also conduct research and train students and the postgraduate mental health workforce. In these settings, importance is attached to expertise, professionalism, and results in the form of students trained, grants awarded, and papers published.

104. **Clinical mental health services also operate within a complex legislative and regulatory environment**. In Victoria, clinical mental health services are subject to accreditation by the Australian Council on Healthcare Standards[100]. Credentialled clinicians are registered by the Australian Health Practitioners Regulation Agency (**AHPRA**)[101]. The care of compulsory patients is regulated by the Mental Health Act (2014), Mental Health Regulations (2014)[102], and Mental Health Tribunal Rules (2014). The list of acts and regulations administered by the Victorian DHHS, many of which directly shape the obligations of clinical mental health services under law,

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[100] Australian Council of Healthcare Standards, 'The National Standards for Mental Health Services', < https://www.achs.org.au/programs-services/national-standards-for-mental-health-services-(nsmhs)/> [accessed 11 August 2020].

[101] Australian Health and Practitioner Regulation Agency, <https://www.ahpra.gov.au/> [accessed 11 August 2020].

[102] Department of Health and Human Services, 'Mental Health Act 2014', <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014> [accessed 11 August 2020].

numbers over 70[103]. Deaths and other adverse incidents are typically subject to investigation by the State Coroner, Safer Care Victoria, the Office of the Chief Psychiatrist and increasingly Worksafe. Clinical and financial performance is monitored by DHHS. This is not to suggest the framework is unreasonable, only that the requirements of compliance are high and the impact on health services is to draw attention towards these elements of service administration.

105. An interesting problem arises when we consider what can be conflicting priorities of service providers, service users and the communities that create the authorising environment in which mental health services operate. Clinicians are trained to deliver specific diagnostic or therapeutic interventions safely. Minimising variation in care is seen as a way of achieving this. They are also rewarded for being caring, creative and innovative, outcomes that typically require customisation to the individual receiving care. Consumers and carers have told the Royal Commission that they value care that is person-centred and meets their need for respect, emotional support, physical comfort, communication, continuity, and the involvement of family and carers[104]. Yet they also seek care that is accessible, predictable, and does not cause harm. Communities despair at narratives of human rights violations in healthcare. And yet there are demands for institutionalisation of the mentally ill in various quarters of the community and criticism when clients treated in the community cause harm to others. How is this tension to be resolved?

BUILDING AND SUSTAINING CULTURES OF OPENNESS, EXCELLENCE AND PROBLEM SOLVING

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[103] Department of Health and Human Services, 'Health legislation overview', <https://www2.health.vic.gov.au/about/legislation/overview> [accessed 11 August 2020].

[104] Australian Commission on Safety and Quality in Healthcare 'Person-centred care' <https://www.safetyandquality.gov.au/our-work/partnering-consumers/person-centred-care> [accessed 11 August 2020]

106. **Health services that consider financial, legal, clinical and operational risks as their key priorities,** lean towards structured process, shared norms, planning and preparedness, decisive crisis management and demonstrable results. In the Integrated Culture Framework, the culture of such organisations tends to favour order, safety, authority and results (in the bottom half of diagram 1 in paragraph 4.6). In the Adaptive Culture Framework, organisational culture prioritizes compliance and achievement (stages 2 and 3 in diagram 2 in paragraph 4.6) **When health services prioritize person-centredness, flexibility and connection**, organisational culture as defined by the Integrated Cultures Framework leans towards caring, purpose and learning (in the top half of diagram 1). In the Adaptive Culture Framework, these priorities could lead to a collaborative growth culture, and possibly a co-creation culture. The development of a co-creation culture is consistent with the intention expressed by the Royal Commissioner to:

107. *"…. work with people living with mental illness, their families and carers to fully understand what they value, what they seek and what they think are the most important features of a future mental health system. This will be the beacon that guides the Commission's work*[105]*."*

108. **Alfred Mental and Addiction Health dealt with this tension by allowing for the possibility of more than one set of dominant values to emerge**, so that ideas could be incubated, tested and then carried across program streams if demonstrated to have value. In my 2019 witness statement, I described the impact of commissioning headspace services on the mental health program. Alfred Health is the lead agency for the headspace Elsternwick centre and the Southern Melbourne headspace Youth Early Psychosis Program (**hYEPP**). We approached our relationship with headspace as an opportunity to create and innovate in a relatively low risk environment. Ideas prototyped at the headspace centre, were

[105] Royal Commission into Victoria's Mental Health System Interim Report, 2019, 585.

scaled up across the child and youth program stream first and then the adult community program. In this way, the Discovery College established within the hYEPP in 2015, was expanded into the adult program in 2020. Single session family therapy, introduced into the headspace centre in 2010, was extended into the emergency program in 2014, the adult community program in 2016 and HOPE in 2018. The organisation defines its mission and its values in terms that are relevant to all settings and client groups in the mental health program. Behaviours that lean towards compliance, consistency, predictability are valued and rewarded in inpatient and emergency settings where clinical risks are highest. Behaviours that lean back towards client autonomy, creative solutions to complex client circumstances, and innovative models of care that engage communities and disrupt existing hierarchies fit better in community settings, where clients are well known, and client risks are lower.

109. **I would like to make a comment about risk.** An orientation to risk could be seen as competing with person-centredness, innovation and humanistic care. Processes intended to ensure that clinical decisions are made transparently and consistently if there is a possibility of harm, are considered "medicalized" and not person-centred. Tell that to the families bereaved when an admitted patient dies by hanging in their hospital bedroom; to the mother of a young adult who is sent home from the emergency department and never makes it to the next mental health appointment; to the nurse who suffers injuries as a result of an assault by a consumer in hospital or during a community visit; to the consumer who is sexually assaulted during a mental health admission; and to the health service CEO having to explain to her board rising insurance premiums as a result of negligence and worker's compensation claims and the compromises to other areas of activity needed to pay for it. The management of individual and organisational risk is a critical component of health service delivery and should not be minimised in importance. The challenge is to ensure that the desire to prevent harm is balanced with an understanding of what good mental healthcare looks like. In achieving this objective, organisations must develop an adaptive capacity that allows for multiple mindsets to operate in a complex environment. I have already written about post-conventional action logics

that allow individuals to apply multiple perspectives to complex problems that demand systemic action. The same applies to healthcare organisations and the mental health services they operate, as they weigh up the balance between therapeutic outcomes and preventing harm.

110. **So, what does the process of transitioning achievement-oriented organisational cultures transition to collaboration and co-creation look like**? Changes are evident in the development of individuals, social networks and organisational systems. Efforts directed at the level of the individual may be facilitated by the organisation or self-led and may involve a focus on self-awareness and an orientation to impact, value and wellbeing. Social connections within all levels of the organisation and beyond create a capacity for collaboration and a wider network of stakeholders. Partnerships involve creating shared value and sustainable solutions. Adaptive systems are characterised by fluidity of roles, process and strategies to meet a range of future possibilities. Wider distribution of leadership is necessary, and authority is no longer restricted to a few. Systems perspectives are increasingly favoured as connections between individuals, teams and the wider organisation are understood and recognised as reciprocal. Network leadership and complex thinking are sought to flesh out social, cultural, environmental and technical issues which may paradoxically inhibit or energise sustainable visions.

111. **And how can this be achieved**? There must be investment in individual and organisational development. The activities that can support individual change and growth include coaching and multidisciplinary education that takes account of perspectives outside of mental health and health. An element of this process should embrace adaptive and transformational work that challenges established assumptions about power, safety and change. Professional and organisational interests must be addressed, as existing arrangements that allocate power and prestige across all disciplines and sectors will not be abandoned without effort. Transforming the culture of a whole health system such as the Victorian Mental Health System would be a complex, multi-level and uncertain process, comprising a

range of interlocking strategies and supporting tactics unfolding over a period of years. Key factors that could impede culture change across a range of sectors include inadequate or inappropriate leadership constraints imposed by external stakeholders and professional allegiances; perceived lack of ownership; and subcultural diversity within health care organisations and systems.[106]

112. I have already written about setting up a Mental Health Leadership Faculty within the Victorian Collaborative Centre for Mental Health and Wellbeing as an instrument of leadership development in the Victorian mental health system. I have also written about the link between leadership and culture. A Mental Health Leadership Faculty within the Victorian Collaborative Centre could provide a mechanism through which organisational culture can be shaped and influenced.

113. But of course, there will need to be more. I believe that a focus on culture in mental health services, as a subset of health or non-government services, must be developed with a view to ensuring that cultural change is seen as a priority in that sector. Human service professionals, chief executive officers and health service boards must develop an awareness of cultural issues in their mental health services because of the link with client outcomes and the need to prioritise mental health reform. Presently, the People Matter Survey is the principle instrument through which staff attitudes, belief and behaviours in public health services are monitored[107]. The survey themes include "You and your job"; "Your workgroup"; "Your manager"; "Senior Leaders"; "Your organisation"; "Patient Safety"; "Your experiences"; "Unacceptable behaviours"; and "Taking Action". The survey is conducted annually, with results reported to chief executives, health service boards

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[106] Scott T et al. 'Implementing culture change in healthcare: theory and practice', *International Journal of Quality Healthcare* 15 (2) (2003), 111-118.

[107] Victorian Public Sector Commission, '2020 People Matter Survey Wellbeing Check', <https://vpsc.vic.gov.au/data-and-research/people-matter-survey/> [accessed 11 August].

and the Victorian government, with an expectation that action is taken to respond to its findings.

114. I believe the survey is useful as an instrument of monitoring organisational culture because its findings are considered at all levels of an organisation and actions are undertaken in response to them, sending a powerful message to all stakeholders. Its impact in mental health settings remains limited, chiefly I believe because it is promoted as an instrument through which feedback about the organisation can be provided and not one through which better client outcomes can be achieved (which I think is where the chain of consequence eventually leads). The body that ultimately provides system stewardship of the Mental Health System in Victoria (presently the Mental Health and Drugs Branch) would do well to conduct its own analysis of data relevant to clinical and non-clinical mental health services and use this to drive conversations and actions about culture in the sector. The survey could also be amended to include more specific questions about attitudes, beliefs and behaviours towards consumers and carers, including those concerning human rights, carer involvement, information sharing, supported decision making, communication and restrictive interventions. Data obtained in this way could drive improvement activity within mental health services and the sector, for which health service executives and boards could be accountable back to the Victorian government.

4. GOVERNANCE IN MENTAL HEALTH SERVICES

EMPOWERING MENTAL HEALTH SERVICE PROVIDERS TO DELIVER IMPROVED OUTCOMES FOR CONSUMERS, CARERS and FAMILIES

116. The development of better linkages between mental health services in the general health sector and non-government agencies has been a focus for mental health reform nationally in Australia since the First National Mental Health Plan was established in 1993[108]. This continued experience of service fragmentation and discontinuity has remained unresolved despite numerous reports and inquiries that have identified it as a source of crisis and evidence of a "broken" system. Specialist hospital and community clinical mental health services are run by local public health services. Community health and non-government organisations largely manage psycho-social services such as the State-funded Early Intervention Psychosocial Support Response (**EIPSR**), and the Commonwealth-funded NDIS and Primary Health Network (**PHN**)-commissioned initiatives[109]. The commissioning of primary mental health services by the PHNs is open to collaboration with existing State-funded services, but typically coordination is limited by barriers to participation and cross-referral. Regional data describing the outputs and outcomes of Commonwealth-funded services are not available, meaning that opportunities for co-ordination of place-based services are limited. Linkages with other State government services health functions such as alcohol and other drug services, and social care services including housing, employment support and family violence services have only started emerging in recent years. All of this could change with a commitment to working together that is underpinned by shared data about activity,

[108] Department of Health, 'First National Mental Health Plan', < https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-i-midrev2-toc~mental-pubs-i-midrev2-2~mental-pubs-i-midrev2-2-fir>

[109] Including headspace, youth severe mental health services, stepped care initiatives for working age adults, and psychological services for older persons living in residential aged care.

outputs and outcomes and that is organized around catchments to enable local planning.

117. Governance looms large as an activity through which health service providers are enabled to deliver improved outcomes for consumers, families and carers. Often misunderstood, governance involves setting a strategic direction for the organisation or service system and holding the responsible executives accountable for the delivery of outcomes. In Victoria's devolved mental health system there are two levels of authority and accountability, each of which contributes to the impact of the system on service users. A common thread at both levels is the lack of visibility of the mental health system for the most senior leaders.

MENTAL HEALTH SYSTEM STEWARDSHIP BY THE VICTORIAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

118. DHHS through the Health and Wellbeing Division (**HWBD**) and the Mental Health and Drugs Branch (**MHDB**) functions as a steward of Victoria's mental health system, formulating policy, commissioning services and managing performance. In managing service performance, DHHS sets high-level expectations for health services and holds them to account for delivery. Examples of how performance monitoring has been used successfully to drive improvement in Victoria's mental health system are limited, but they do exist. An effective use of performance measures to this end was the introduction of a target of 15 episodes of seclusion per 1000 occupied bed-days (**OBD**) about a decade ago. Since then, there has been a marked decrease in the use of restrictive interventions in Victoria, such that in the third quarter of 2019-20, the State-wide average was 9.1 episodes/1000 OBD[110] compared to 23.7 episodes/1000 OBD ten years earlier in the third quarter

[110] Department of Health and Human Services, 'Adult Mental Health Performance Indicator Report 2018–19 – Quarter 3' < https://www2.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports/~/link.aspx?_id=9D5E1A98EA6E44639F0386FC53FAB185and_z=z>.

of 2009-10[111]. Clearly, there are many factors that require consideration in interpreting this data, not the least of which is time spent in seclusion. That said, a focus from DHHS on an outcome of real significance in clinical practice has been a catalyst for legislative reform (in the form of the Mental Health Act 2014), practice change (in the implementation of Safewards and the development of behavioural emergency team protocols) and design improvements (in the innovations in ward design seen in recent capital developments in acute mental health).

119. Despite this, performance measurement as a driver for reform has been underutilized in Victoria's Mental Health System and this needs to change. The establishment of the Victorian Agency for Health Information has created a capacity within the Victorian government to produce and report on a range of indicators across all parts of the mental health system. Improved system performance for mental health consumers, families and carers could be achieved by extending the present focus on financial performance, input and activity to include outputs and outcomes. I have already shared a view about what this could comprise and how this could influence what health service CEOs and boards regarded as important. I have also written that what is measured and rewarded can shape organisational culture and by extension organisational outcomes.[112] Linking outputs and outcomes to an activity-based funding model could provide further critical leverage in the reform process by linking performance and funding to outputs and outcomes.

120. Reporting on the performance of community health and non-government agencies delivering psychosocial care to people with mental illness would extend the current understanding of mental health system performance beyond the clinical sector and this will change perspectives about what is important and what makes a difference

[111] Department of Health and Human Services, 'Adult Mental Health Performance Indicator Report 2018–19 – Quarter 3' < https://www2.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports/~/link.aspx?_id=9D5E1A98EA6E44639F0386FC53FAB185and_z=z>.

[112] See Paragraph 2.25.

to client and family outcomes. This kind of reporting and transparency could also be an impetus for improved service integration. The Victorian government provides substantial funding to community health and non-government agencies to deliver mental health care and should use this as leverage to require reporting and performance targets. In this way, DHHS could ensure that primary mental health (eg telephone counselling) and psychosocial services (eg. counselling, social skills training, group activities) are used in a way that optimally reduces demand in the clinical sector and improves outcomes for clients with moderate and severe mental illness. This could be strengthened by a common approach to shared complex clients supported by a common registration process, and shared data. A performance reporting system that monitors indicators measuring activity, outputs and outcomes in the community health, non-government and clinical sectors, and that links funding to those indicators, would provide opportunities for improvement that are difficult to anticipate in advance of such a system being made possible.

121. After the final report of the Royal Commission is submitted in February 2021, it is imperative in my opinion that mental health is governed differently within DHHS than is the case at present. The establishment of MHRV as an administrative office has demonstrated to my mind the value of this structure in elevating mental health issues as a priority within DHHS. The reporting of the Chief Executive Officer directly to the Minister for Mental Health and the Secretary of the Department allows for far greater accountability for mental health reform. It also ensures that mental health is increasingly incorporated as a key consideration in the core work undertaken in response to a host of priorities. This has been most apparent in the response to COVID-19, which has placed mental health close to the centre of the response phase and at the forefront of the recovery phase. Establishing an administrative office to succeed MHRV and to integrate implementation of reform, policy, commissioning and oversight of performance should be considered after 2022.

MENTAL HEALTH SERVICE STEWARDSHIP BY LOCAL HEALTH SERVICES

122. At a health service level, clinical mental health services operate within a health service governance framework. It is my firm belief that **the integration of public mental health and public health services should be maintained**.

a) The governance requirements of health and mental health services are similar in both systems of care, in that they are required to ensure effective and efficient provision of services by managing demand, containing costs, attracting and retaining funding and a healthcare workforce and meeting financial, access, quality and efficiency performance objectives[113].

b) By any measure, mental illness, substance-related disorders and suicide and self-inflicted injuries are health problems and mental health is a key public health priority. Mental and behavioural disorders accounted for 12% of the total burden of disease nationally in 2015[114], including alcohol use disorders at 1.4%. Separately, suicide accounted for 2.8% of the total burden of disease.[115]

c) Many of the challenges being confronted by the mental health system are shared by the general health system. These include disease prevention, early intervention, the management of chronic disease in the community, alternatives

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[113] Victorian Department of Health, The Victorian health services governance handbook: A resource for Victorian health services and their boards, 2012.

[114] This is expressed as Disability Adjusted Life Years (DALY) or years lost due to premature death added to years lived with disability (YLL and YLD).

[115] Australian Institute of Health and Welfare,'Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015—Summary report. Australian Burden of Disease Study series no. 18. Cat. no. BOD 21. Canberra: AIHW < https://www.aihw.gov.au/getmedia/08eb5dd0-a7c0-429a-b35f-c8275e7a1dbf/aihw-bod-21.pdf.aspx?inline=true>.

to hospitalisation such as hospital in the home, and the application of digital technologies such as telehealth and electronic medical records.

d) Only the health system can provide mental health services with the visibility to government and the operational capacity to respond to complex emerging problems. And only public health services have the infrastructure and the breadth of service provision to support the academic and training requirements of a growing clinical workforce.

e) The Royal Commission has received submissions arguing for a return to stand-alone mental health service governance[116]. While attractive in that it would allow for integration of hospital and community mental health, I believe that the risks vastly outweigh the benefits of such a governance arrangement. A stand-alone mental health system would lose contact with the innovation and service developments occurring in general health, many of which provide models for mental health services to adapt. If hospital and emergency mental health services presently co-located with public hospitals were managed separately, this would result in the fragmentation and discontinuity of care already evident in services where such arrangements already exist. Equally, general health would be the poorer given the increasing complexity of the patients treated in that system, the greater demand for mental health input into medical and surgical units and the greater capacity of mental health to model the kinds of community care approaches that are of increasing interest to sectors such as geriatrics and general medicine.

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[116] opolov D, Bastianpillai T and The Adult Psychiatry Imperative Consortium. 'The Adult Psychiatry Imperative: Achieving parity of care', Submission to the Royal Commission into Victoria's Mental Health System, 2019 <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/4815/6858/2736/The_Adult_Psychiatry_Imperative_update.pdf>.

123. Despite the advantages of integrating the governance of public health and mental health services, risks emerge because the process and context of mental health care can be difficult to define and measure, and the needs of the health service more broadly can dwarf those of the mental health component. This combination of factors means that it can be easy to lose sight of and exercise meaningful mental health governance at a board level. There is a need for clear external levers that support executive focus and oversight on improved outcomes and not just the financial legal, clinical and operational risks. The oversight of mental health services within local health services could be enhanced by:

a) **Changes to the performance framework** of the kind I outlined earlier in paragraph 2.20.3 to include health, social and system domain indicators. These could reflect client and family priorities, their experience of care, and their reported outcomes, as well as the delivery of evidence-based treatments including psychological and social interventions.

b) **Greater financial accountability** for spending of the mental health budget that sets targets for the proportion of the budget spent directly on mental health services. In West Australia, the Mental Health Commission there limits operational overheads to about 12% of total budget, for example.[117]

c) **The creation of a Mental Health subcommittee of the health service board**. This would have a skills-based membership that would include people with clinical and lived experience and members of the community with any one of a range of related skills such as communication, digital technologies, system design and thinking, implementation science, leadership and culture, and community development, to name a few, all underpinned by a passion for mental health and mental illness. The subcommittee would report directly to the health

[117] Tim Marney, former Mental Health Commissioner West Australia, Personal Communication, 22 June 2020.

service board. By virtue of its greater subject matter expertise, it will be able to advise local public health service boards about strategy, financial and clinical performance, organisational culture and risk, community partnerships and participation and will be able to ensure transparency of reporting to the local community.

124. **The integration of hospital and community clinical mental health services should be maintained**. Earlier in this witness statement, I wrote about how changes to the culture and climate of organisations can be managed in order to create the flexibility required of the different elements of care provided by mental health services. The present challenges are in no small part due to twenty-five years of underinvestment in service capacity, quality improvement, and system leadership and culture, as reflected by the lowest level of funding per capita in the country[118] and the Premier's conclusion that this is a "broken system". Given the perceived crisis in mental health in Victoria, it would be tempting to assume that health services have not been good custodians of the mental health system, in particular community mental health. I think it is important to resist that temptation. Problems attributed to institutional closures and mental health reform often reflect flawed and incomplete implementation[119]. These have been well documented in the Interim Report of the RCVMHS. The solution does not lie in separating hospital and emergency from community and continuing care mental health services. To do so will add to the fragmentation of care, create competition between elements of the sector, impede collaboration, harm consumer and carer outcomes, and increasingly lead to a weakening of the education, training and supervision required to develop

[118] $227.74 per capita per annum in 2017-18 compared to $243.76 nationally. See: Australian Institute of Health and Welfare, 'Mental health Services in Australia' <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services/specialised-mental-health-services-expenditure> [accessed 11 August 2020].

[119] Gerrand V. 'Can deinstitutionalisation work? Mental health reform from 1993 to 1998 in Victoria, Australia', *Health Sociology Review*; 14 (3) (2005), 255-271.

the technical and leadership capacity of the mental health workforce. It would separate the hospital and emergency mental healthcare system from elements that could drive more collaborative and participatory behaviours and facilitate its retreat to cultures of compliance and regulation. It could also separate the community and continuing care mental health system from elements that promote the safety, coordination and continuity of clinical care for consumers with complex needs.

125. Changes to the governance arrangements of mental health services may remove barriers to reform. They may also result in unintended consequences. I have already commented that if we assert that mental health reform is an adaptive challenge, then it follows that the present system is designed perfectly to achieve the outcomes being produced. Solutions lie in understanding the factors that shape how power is used, how people are motivated, and what behaviours are rewarded. Having earlier outlined my concerns about a return to stand-alone mental health services, there are other structural governance alternatives I would like to consider.

a) It is difficult to imagine how the governance of hospital and emergency mental health services could be improved by any arrangement other than one which involves integration with co-located public health services. The difficult experience of having hospital and emergency mental health services at Northern Health and Western Health managed by Melbourne Health is well known to the Commission and should suffice as a guide in that regard.

b) The experience of commissioning non-government organisations (**NGOs**) to deliver primary mental health services by Primary Health Networks is highly variable and no convincing evaluation data exists to give the Royal Commission comfort that NGOs can deliver the mental health reform that is being sought. In my experience as a clinical director managing a headspace primary centre and as a clinical advisor in several PHN-managed tenders for stepped mental healthcare services, there has been little evidence to suggest that commissioning clinical community mental health services by non-clinical organisations will enable the clinical outcomes, the workforce transformation and

the learning and development needed to change the system for the better. Professor Anthony Jorm has written that improvements in headspace clients are like those seen in untreated cases[120]. Recommendation 24.2 of the Productivity Commission Draft Report into Mental Health states: "In the short term, the Department of Health should cease directing PHNs to fund headspace centres, including the headspace Youth Early Psychosis Program, and other specific service providers. PHNs should be able to continue funding headspace services or redirect this funding to better meet the needs of their local areas as they see fit."[121] I must emphasise that I do not support the view that headspace primary and the headspace youth early psychosis program are ineffective, though I do believe that the evidence cannot be discounted. In my opinion, the problem could lie with the reliance upon non-clinical actors to deliver clinical services and that this is a hypothesis that must be evaluated appropriately.

c) In a similar way, the governance of clinical community and continuing care mental health services by the community health sector is also untested and is likely to present its own unintended consequences. The state-funded community health program operates under two distinct legal and governance arrangements. Fifty-five community health services operate as part of a regional or metropolitan public health service and are subject to the same accountability frameworks as the broader health service. Thirty registered community health services operate as companies limited by guarantee. The community health sector is beset by similar problems to the mental health sector in that it is unclear whether services are targeting priority populations; whether care is timely, effective and appropriate; and whether the system has the capacity to meet demand. Improvements in funding models and data about performance and quality are

[120] Jorm AF, 'Headspace: The gap between the evidence and the arguments', *Australian and New Zealand Journal of Psychiatry*, 50 (3) (2016), 195-196.

[121] Productivity Commission. Draft Report. Mental Health. Op cit. page 106.

required, according to the Victorian Auditor-General's Office[122]. Complexities in maintaining clinical standards will arise in such a governance arrangement, as will difficulties in attracting, training and retaining a clinical workforce. Shifting the governance of community and continuing care mental health services to community health will mean a great deal of disruption for most mental health services, with little benefit in that most will continue to be managed by health services and many of the systemic barriers to mental health reform will remain unchanged.

126. The present arrangement whereby public mental health services cater to defined catchments is undoubtedly not working well because it has been poorly managed, a fact that has been previously acknowledged[123]. The structure involves a confusingly large number of clinical mental health service entities that often lack a clear geographical relationship with the broader health services that manage them. Catchments for Child and Youth, Adult and Older Persons services typically do not align with one another, or with other types of health and human services, or with PHNs or local government areas (**LGAs**). The populations covered vary markedly between 250,000 and 1,300,000 people. I am aware of feedback from consumers and carers that the allocation of catchments to mental health services denies them adequate choice.

127. Despite these problems, I believe that some, though not all, elements of the catchment model should be retained.

128. Catchments remain a superior arrangement for delivering a full suite of coordinated ambulatory, outreach and hospital-based services to complex clients with multiple

[122] Victorian Auditor-General's Office. Community Health Program. June 2018.

[123] Victorian Department of Health, Consultation Paper: Clinical Mental Health Service Catchments, August 2013 <https://www2.health.vic.gov.au/Api/downloadmedia/%7B4355303B-2D06-4190-AEC8-C78681867CD3%7D>.

needs. There are many reasons for this. Allocating exclusive responsibility to mental health services for all consumers living in a defined catchment area should create an opportunity to provide care that is coordinated and delivered by clinicians known to the consumer and their family. Catchment responsibility also requires mental health services to be accountable for complex clients, who would otherwise fall between the cracks in a system which allowed services to refuse clients who pose specific risks, related to behaviour or cost for example. The proposal by the Productivity Commission in its Mental Health draft report, to create pooled funding for clinical and psychosocial activity implies that relationships between public mental health services, PHNs, LGAs and NGOs will need to be strengthened to form regional partnerships.

129. Nevertheless, there is much that needs to be improved. Catchment boundaries of area mental health services (**AMHS**) should be aligned with LGA and PHN boundaries in order to allow for collaboration with local government and Commonwealth-funded initiatives including those commissioned by PHN and the NDIS. AMHS should be organized into regional partnerships, covering areas that align with PHN boundaries. Within these regional partnerships, each AMHS should provide a range of core services for all age groups, including perinatal services. Sub-specialist services, such as eating disorders and neuropsychiatry could be provided on a hub- and-spoke basis with specialist bed-based services in a regional centre and outpatient services located in each catchment. The benchmark population should be between 500,000-750,000 people. The geographic boundaries of catchments should be reviewed on a regular basis in order to adjust to changes in population and regional changes in the burden of disease. Resource allocation should reflect such changes if catchments are to remain meaningful and useful over a longer period. Consumer choice should also be enhanced. Patients admitted to hospital should never be transferred to another hospital because of their residential address, unless at the request of the consumer or family. Patients should be admitted to the closest hospital unit available to them at the time of their emergency presentation, in the same way as applies to non-mental health patients. It is in the community I think that the catchment arrangement makes most sense, and yet this

should only be restricted to clients with complex needs who require care coordination of specialist clinical and psychosocial care and/or compulsory treatment. Clients who require short-term ambulatory care could and should be given choice in a system that is organised along regional lines but does not restrict where clients can seek treatment. A system of registering clients would support choice and flexibility, and this should be underpinned by an activity-based funding mechanism for both hospital and community mental healthcare that would allow services to be paid for the healthcare they provide and therefore to remain sustainable.

ENSURING PEOPLE WITH LIVED EXPERIENCE HAVE A MEANINGFUL AND ENDURING VOICE IN DECISION-MAKING AT ALL LEVELS OF SYSTEM DESIGN, POLICY PLANNING AND SETTING, AND SERVICE DELIVERY

130. Developing a participatory ethic as a key value in Victoria's mental health system must remain a priority to ensure people with lived experience have a meaningful and enduring voice in decision-making at all levels of system design, policy planning and setting and service delivery. This is necessary because the safety and quality of health and social services improve when consumers and their carers have a say in matters that affect their lives[124] [125]. We also know that participation in mental healthcare is difficult and that mental health service users and carers experience barriers, for example, in raising safety concerns[126]. In my experience,

[124] Longtin Y et al. 'Patient participation: current knowledge and applicability to patient safety', *Mayo Clin Proceedings* 85 (1) (2010), 53-62.

[125] Australian Commission on Safety and Quality in Healthcare. Patient-centred care: improving quality and safety through partnerships with patients and consumers, 2011. ACSQHC, Sydney.

[126] Berzins K et al. 'Service user and carer involvement in mental health care safety: raising concerns and improving the safety of services' *BMC Health Services Research* 18 (1) (2018), 1-8.

the involvement of consumers and carers is a key driver for the organisational change and cultural renewal I have already identified as a central requirement of reform. Several government policies and legislative frameworks point to this and are important both for giving authority to this way of delivering services, as well as providing practical tools[127] [128] [129] [130] [131].

131. The involvement of people with lived experience in leadership roles at the level of DHHS is critical in setting the tone for how the system is expected to facilitate the participation of consumers and carers and for modelling the potential benefits. The Mental Health and Drugs Branch has taken the lead in ensuring a team of consumer and carer advisers is in place to inform and contribute to the work of system design and commissioning. Theirs is a fully contributing role and I can attest to the fact that they are an integral part of the team and actively involved in the work being undertaken. Additional guidance about how consumer and carer engagement can be practically implemented at the service level should be developed by the Mental Health and Drugs Branch working with people with lived experience to assist

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[127] Victorian Public Sector Commission, Code of conduct for Victorian public sector employees 2015 requires public officials to demonstrate respect for members of the community by using their views to improve outcomes < https://vpsc.vic.gov.au/resources/code-of-conduct-for-employees/>.

[128] The *Charter of Human Rights and Responsibilities Act 2006* (Vic) sets out the right of every person in Victoria to have the opportunity to participate in the conduct of public affairs. At: https://www.legislation.vic.gov.au/in-force/acts/charter-human-rights-and-responsibilities-act-2006/014

[129] The *Mental Health Act 2014* (Vic) placed people with mental illness and carers at the centre of treatment, care and recovery. At: https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014

[130] *Victoria's 10-year mental health plan* set the scene for improvements driven by public needs and experience.

[131] The Department of Health and Human Services engagement practices are guided by best practice and standards outlined by the International Association for Public Participation (IAP2) *Quality assurance standard for community and stakeholder engagement* and the Victorian Auditor-General's *Public participation in government decision-making: better practice guide*.

the sector in moving towards a standard of best practice. In its engagement with consumers and carers, MHRV has adopted the Mental Health Lived Experience Engagement Framework, coproduced by the MHDB and the Lived Experience Advisory Committee (**LEAG**)[132]. Consultation occurs at several levels including the LEAG and the Mental Health Ministerial Advisory Sub-Committee to ensure people with lived experience are involved in the high-level advice and planning being developed by MHRV. Senior consumer and carer advisers have been recruited and joined the leadership team in July 2020.

132. In health services, a range of lived experience workforce roles have emerged to ensure that the perspectives of people with lived experience are reflected in service design and delivery. Following early setbacks in deploying a peer workforce, Alfred Health developed a workforce framework to more clearly set out the roles and supervisory structures and ensure that these were understood across the program and properly resourced. The work was undertaken to ensure that these roles were provided with adequate support structures (such as recognised training, supervision, remuneration, codes of conduct, and regulation) and recognition of their value (through embedding in multidisciplinary teams).

133. Structures which lift the profile of and perspectives of people with lived experience within health services and DHHS are particularly important, and these need to have an impact on culture at all levels of the mental health system. This means ensuring it is a priority for organisations, such as through a Statement of Priorities. It requires senior clinical leadership to promote the value of these roles through visible consultation, co-design and co-production in the planning and delivery of services. And it demands that organisational structures are created to support and sustain the professional development of the workforce. Many services now have managers or senior practitioners who coordinate the peer workforce and provide supervision,

[132] Department of Health and Human Services, 'Mental Health lived experience engagement framework' <https://www.dhhs.vic.gov.au/publications/mental-health-lived-experience-engagement-framework>.

and some with a large enough peer workforce will need to consider developing executive roles to manage the increasingly complex needs that will emerge.

5. QUALITY IMPROVEMENT, EVALUATION AND RESEARCH

134. I have already written about several of the individual and organisational factors that can influence the emergence of a culture that drives change and embeds innovation, openness and respect. These same factors will also lead to service improvement. Organisations that combine an interest in financial, legal, clinical and operational risks and a drive for person-centredness, respect, dignity, co-design and co-production, tend to shift towards more adaptive frames that allow for greater collaboration and creativity. This is supported by the input of leaders who are inspired by the same values.

135. The Observatory of Public Sector Innovation (**OPSI**) in the Organisation for Economic Cooperation and Development (**OECD**) describes innovation as "the process of implementing novel approaches to achieve impact". Three core dimensions are identified.

a) **Novelty**. Innovation involves introducing entirely new approaches or the application of existing approaches to new contexts;

b) **Implementation**. Innovation must be implemented in some form or have tangible influence; it cannot remain a theoretical idea, a policy on paper, or an invention that is never adopted; and

c) **Impact**. Innovation must result in public outcomes – the change has to be realised in some form. Ideally these outcomes include change for the better and increased satisfaction, as well as efficiency and effectiveness[133].

[133] Observatory of Public Sector Innovation 'Public Sector Innovation Facets' < https://oecd-opsi.org/projects/innovation-facets/ > (Accessed 10 August 2020).

136. Given the difficulty inherent in changing the status quo, innovation is inherently uncertain and rarely happens unless there is some sort of push or pull associated with it. Successful innovation is driven by purpose, without which it is unlikely to progress far, particularly in settings where existing structures, processes or vested interests are likely to act as constraints. The OPSI has developed a framework (see diagram 3) organized around two dimensions:

a) **Is the innovation directed?** For example, does it have a clear intent/objective that it is trying to achieve, or is more about discovery and responding (proactively or reactively) to externally generated change?

b) **Is the innovation dealing with high uncertainty?** For example, is the context one of exploring completely new ground, or is it one **where** things are relatively understood.

137. The OPSI framework identifies four types of public sector innovation that emerge from the two dimensions.

a) **Enhancement-oriented innovation** focuses on upgrading practices, achieving efficiencies and better results, and building on existing structures, rather than challenging the status quo. This is traditionally where most governments have focused their innovation efforts.

b) **Mission-oriented innovation** is where there is a clear outcome or overarching objective for which innovation is harnessed. There is a clear direction, even if the specifics of how it will be achieved may be uncertain. This type of innovation can range from the incremental to the more radical, but may often fit within, rather than subverting, existing paradigms.

c) **Adaptive innovation** is often driven by new knowledge or the changing environment. When the environment changes, perhaps because of the introduction of innovation by others (e.g. a new technology or new practices), it

can be necessary to respond with innovation that helps adapt to the change or put forward something just because it has become possible.

d) **Anticipatory innovation** is primarily concerned with exploration and engagement with emergent issues that might shape future priorities and future commitments. Anticipatory innovation generally requires being sheltered from core business and having autonomy, as otherwise the pressures of existing priorities are likely to take over any resources that are dedicated to an initiative that is uncertain and without any guarantee of success.

DIAGRAM 3: OPSI PUBLIC SECTOR INNOVATION FRAMEWORK (OPSI, accessed Aug 2020; ref 133)

138. The ability to successfully utilise the different public sector innovation facets within a system depends upon there being a degree of innovation "readiness" as innovation greatly depends on the existing knowledge, skills and processes. A focus on facilitating and aligning incentives to encourage these factors is important in developing and implementing innovative service models that meet consumer needs. Again, the utility of funding models is apparent, and a fundamental step can involve aligning system objectives and funding models to outcomes that consumers most care about. Another important contribution comes from valuing and prioritising the knowledge and experience of consumers and carers in a systemic way through

training and processes that involve people with lived experience as a matter of course.

139. The establishment of the Victorian Collaborative Centre for Mental Health and Wellbeing should contribute to creating a culture of innovation, as its role will include driving 'exemplary practice for the full and effective participation and inclusion of people with lived experience across the mental health system'. Furthermore, its research and practice should align with the needs of people with lived experience and its advances should be shared and applied across the State's mental health system. Over coming months, MHRV will begin the codesign process with people with lived experience at the centre of the process to ensure that the Collaborative Centre meets these objectives.

MECHANISMS TO HELP FACILITATE CONTINUOUS IMPROVEMENT OF SERVICE DELIVERY

140. For health services to be able to deliver and commit to continuous improvement, they need alignment throughout the organisation of what their improvement direction is (a clear shared goal), and the requisite skills, tools, time, focus and capability to follow this through. At the level of clinical, support and peer workers, education and training can support the development of continuous improvement. Capability and process investments are needed for this to be sustained over time, and this would include skills training of consumers, clinicians, senior leaders and boards; coaching, mentoring, and peer collaboration; and the establishment of clinical networks focussed on explicit service improvement goals to be scaled across the health care system, underpinned by a focus on data and the implementation of evidence informed practice. Safer Care Victoria has started to use the latter approach with respect to mental health, but I am not aware of its widespread structured adoption at the service level.

141. At the level of the mental healthcare system, there is need for mindset shift that embeds continuous improvement of service delivery with a focus on improved outcomes as an accountability measure for health services. This moves from a set and forget approach to service performance to one where continuous improvement is a fundamental requirement. There is very mixed evidence in systemic use of pay for performance – particularly the use of a nominal bonus for improvement, and this is not recommended. For organisational behaviour to change and be sustained there needs to be alignment of funding, accountability, capability and motivational levers. Again, this mirrors an earlier message in this statement about ways to incentivise changes in organisational culture. Indeed, there is a crucial argument to be made that changing attitudes towards innovation, service improvement, and client-centredness overlaps with driving organisational cultures towards frameworks that favour collaboration and co-creation.

EMBEDDING INNOVATION CULTURES AND 'CYCLES OF LEARNING' INTO SERVICE STRUCTURES AND ENVIRONMENTS

142. In its report, '*Creating the Culture for Innovation*', the NHS Institute for Innovation and Improvement identified seven key dimensions of culture that distinguish highly innovative health organisations. These are summarised below and provide a good overview of how to embed innovation cultures into service structures and environments[134].

[134]Maher L, Plsek P, Price J & Mugglestone M. Creating the culture for innovation. A practical guide for leaders. NHS Institute for Innovation & Improvement. 2010. At: https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Creating-the-Culture-for-Innovation-Practical-Guide-for-Leaders.pdf

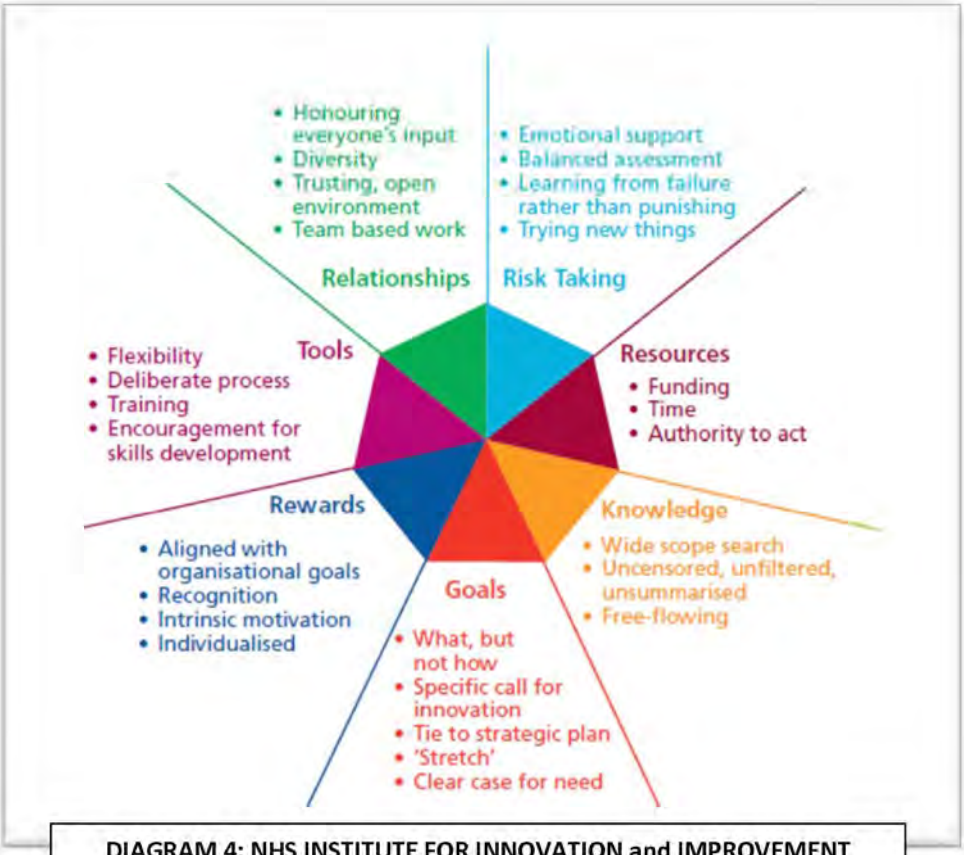

DIAGRAM 4: NHS INSTITUTE FOR INNOVATION and IMPROVEMENT CULTURAL FRAMEWORK FOR INNOVATION (Maher et al, 2010)

a) **Risk taking** requires establishing an organisational climate where people feel able to test new ideas. While it is obviously important to avoid taking

inappropriate risk, a healthy organisational culture seeks a balanced assessment that avoids prematurely rejecting ideas due to an over-estimation of risk. It also requires leaders who show they are quick to provide emotional support to those willing to try something new, regardless of whether the idea is eventually judged a success or 'failure'. Leaders in innovative organisations demonstrate that they are more interested in learning from failure than in punishing it. A process-driven approach to innovation that attempts to anticipate risk, seeks stakeholder participation and the informed consent of consumer and family helps to reduce adverse consequences and organisational risk.

b) The climate for innovation is **enhanced** if people know that they have the **'resource'** of funding, authority and autonomy to act on innovative ideas. While innovative ideas do not necessarily need a lot of money or time to develop, staff can become demoralised if these traditional resources are not available and can feel that there is no point in putting forward a new idea. The presence of identifiable resources signal that the organisation is taking innovation seriously. In many health services, organisations create innovation pools of funding often from philanthropic donations, to resource pilot programs or small research projects. The signals these send to staff about the openness of organisations to change and new ideas can be powerful.

c) Broad-based **knowledge** is the fuel for innovation. Better conditions for innovation are created when information, both from within and outside the organisation or system, is widely gathered, easily accessible, rapidly transmitted, and honestly communicated. Since we cannot know in advance

what knowledge might stimulate an innovative idea, censoring, filtering or over-summarising information detracts from this dimension.

d) Organisational and system leaders signal that innovation is highly desirable by setting aspirational **goals** in specific areas and challenging others to find ways to realise the vision. Linking these to strategic priorities and being able to articulate a clear, multifaceted case of need, further signals the importance of the call for innovation. However, there is a caution. Innovative thinking is stifled when leaders go beyond statements of what needs to be achieved and become prescriptive as to how it must be achieved.

e) **Rewards** for innovation are symbols and rituals whose main purpose is to recognise innovative behaviour. They signal how much value is given, or not given, to the efforts of individuals and teams who come up with new ways to help the organisation or system achieve its strategic goals. Because it is all about encouraging more of this sort of behaviour, the best recognition is that which appeals to people's intrinsic and individualised motivation. The most successful recognition schemes avoid a one-size-fits-all approach and are instead based on a deeper understanding of what motivates people to act. For example, frequent personal expression of appreciation is often more important to people than financial reward.

f) In high-performing organisations, innovation is the product of the deliberate use of practical **tools**. Imagining that innovation will happen on its own if the right culture is in place would be as naive and irresponsible as imagining that financial controls would naturally emerge without deliberate structures.

While everyone is capable of innovative thinking, most of us have been socialised to be more conservative in our thinking in the work environment, especially in health care where there are legitimate risks that must be managed. Leaders, therefore, need to consider how they build capability and capacity in deliberate methods for creative thinking.

g) The **relationships** dimension refers to the patterns of interaction between people in the organisation or system. Innovative ideas are rarely the product of a lone genius. Even when they might appear to be, delving further into the story nearly always reveals that the idea was formed over time and through multiple interactions with others that fuelled the process. Therefore, settings in which staff are routinely exposed to diverse thinking provide rich soil for the growth of innovation. Of course, what is required is more than just exposure; one can be 'exposed' to a diverse group of people while riding on a train and not be stimulated to innovate. There must be a sense of common purpose and of being in a 'team' with others. This team environment must also enable those with different thinking to trust that their input will be honoured and explored, rather than immediately argued against.

143. The features I wrote about in my 2019 witness statement needed to imbed a culture of change and constant learning in the mental health system, echo features of the frameworks for innovation produced by the Observatory of Public Sector Innovation of the OECD and the NHS Institute for Innovation and Improvement. Extrapolating from that, I would suggest that in my experience of managing a Victorian Area Mental Health Service, successful innovation was enabled through several factors that were interrelated and largely shaped and influenced the other. These included:

a) **The availability of new sources of funding that allowed for growth**, first through tenders that led to opportunities outside the normal allocations for

mental health activity, and then through real growth in State funding for core mental health services.

b) **Implementing new programs that shaped culture change and inspired innovation in other parts of the mental health service.** Examples included commissioning of the demonstration project for Child and Youth services, headspace Elsternwick and the Southern Melbourne Youth Early Psychosis Program (**YEPP**), a State-wide Problem Gambling and Mental Health service, the Hospital Outreach Post-Suicidal Engagement service and a Mental Health and Addiction Emergency Hub among others. While policy mapped the way forward, and funding made it possible, the practical experience of commissioning innovative programs and implementing new models of care helped shift staff attitudes and beliefs, changed important elements of organisational culture and made further innovation and experimentation in other parts of the service possible.

c) **An openness to co-design.** This is a capacity that grew progressively. As would be anticipated from the earlier description by Braithwaite et al of the factors that underpin successful healthcare reform[135], the introduction of co-design at Alfred Health required a focus on several factors. Purpose and accountability; the leadership of lived experience challenging the service to do better; clinical and operational champions to create space for clinicians and peer workers to build trust and capability; stakeholder engagement; and time all played a part in the process of driving the service towards a greater focus on consumer and carer participation. And of course, one cannot ignore the impact that co-design has in creating services that clinicians and consumers want to work in and use, thereby reinforcing the approach and fostering greater interest in it.

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[135] Braithwaite J et al. Op cit.

d) **Organisational support** at every level to trial new ideas, seek solutions to difficult operational problems, provide resources and take risks. The engagement must be reciprocal. Just as boards and health service executives must consider supporting innovative ideas being pitched by mental health services, so too must leaders of mental health services be open to taking up challenges put forward by their health service boards and executives. In my witness statement, I wrote about the willingness of the Alfred Health board and CEO to support the commitment of the mental health service in developing the headspace Youth Early Psychosis Program, even in the face of considerable risk. I also wrote about the preparedness of the mental health service to support the management of behaviours of concern in the general hospitals, a task that has now extended to management of the budget for staff allocations to manage behaviourally disturbed patients (the so-called "nurse specials" or nurses who provide one on one care to patients on hospital wards) with success in making substantial savings through improved assessment, nurse-led interventions and staff education and support.

e) **Building a program infrastructure to support data and analytics, audit, quality improvement, risk management, planning and service development and workforce education and training**. The capacity to provide for this capability was not always been forthcoming. In 2006, when I first started in my role as Program Director of Alfred Psychiatry, the service had about 250 FTE and 5 FTE in Quality and Risk, Health Information and Workforce Support. The service now employs about 800FTE. The Quality and Risk Unit is now made up of about 15 FTE with a Quality and Risk Manager, a Clinical Director of Quality and Risk, and support for Health Information, data analytics, audit and planning, and service accreditation. There is a separate Workforce Development Unit made up of about 10 FTE with nursing, allied health and medical seniors managing undergraduate nursing training; education and supervision for postgraduate medical, nursing and allied health; and junior medical recruitment. The academic unit

manages the deployment of medical students and their education and supervision. These developments have substantially improved the capacity of the service to undertake continuous improvement and have been made possible by growth in community and hospital funding and across the child, youth and adult programs. This capacity is supported by organisational People and Culture supports, including Human Resources, and the Medical, Nursing and Allied Health workforce support units.

144. A further enabler is represented by DHHS and the leadership that it brings to its role as system steward. I have previously written about the importance of funding infrastructure for quality, safety and improvement. This is made possible as a result of decisions made by government and at the departmental level. I have also written about the importance of performance measures and funding mechanisms that link organisational priorities to activities, outputs and outcomes to mental health reform, and by extension quality improvement objectives.

6. WORKFORCE CHANGE READINESS

IMPLICATIONS FOR THE SIZE AND COMPOSITION OF THE WORKFORCE, AND HOW PROFESSIONAL SKILLS AND EXPERTISE ARE DISTRIBUTED

145. The Commission's Interim Report anticipates fundamental reform of the mental health workforce, which will be expected to work in different ways. They will be enabled to continuously improve their practice, and their values and skills will need to adapt to the changing needs and expectations of consumers, families and carers. **Implications for the size and composition of the workforce, and how professional skills and expertise are distributed will be considerable.**

146. **Increasing workforce numbers and continuing to do the same as has been done before** will improve capacity for mental health practitioners by reducing caseloads and creating opportunities for more therapeutic interventions that are relational in nature. Additionally, it may create enough 'fat in the system' to ensure greater access to learning and development, high quality supervision, and leadership development. An absence of non-clinical time is often identified as a barrier to teaching, supervision, reflective practice and leadership training. Despite this, increasing workforce numbers will not in and of itself drive system transformation and cannot be viewed as the only workforce intervention for building capabilities for delivering reform. It has limited power to solve long standing supply, distribution and skill gaps and any enhancement of workforce capacity undertaken in this way is unlikely to resolve inefficiencies that arise from role confusion, duplication, delegation issues and the untapped use of unique specialist skills. For these reasons, workforce size and composition will be impacted by the extent to which effective job redesign focused on capability and efficiency has occurred or not. Workforce modelling needs to be cognisant of this relationship.

147. **Instead of traditional methods of workforce planning, competency-based workforce redesign is increasingly being applied in different jurisdictions outside Australia** to redevelop and reconfigure existing service systems, and to

better respond to issues of high demand, high staff turnover and changing consumer needs. The Competence-Based Approach to Workforce Redesign developed by NHS Wales provides an interesting framework for redesigning workforces with an initial focus on the patient, rather than supply and demand of the existing workforce[136]. This, and similar methodologies, begin by defining a vision for improved or transformed services, with a focus on service user experience and outcomes. To do this, deeply understanding the outcomes produced by a reformed system at the individual consumer, program and system levels is central to designing what service delivery will look like in terms of both what interventions are delivered and how. Both lived experience and workforce perspectives are needed to do this comprehensively, and attention to local needs and community diversity are critical. The model at face value seems to take into consideration both the technical and the adaptive challenges in mental health service delivery by starting with an understanding of what is important to the patient and the key stakeholders. It is only then that the vision of what services will deliver is described, and from this the competencies and job design flows. The components of the model are described as follows: **[1]** Focus on the patient; **[2]** Identification of key stakeholders; **[3]** Define the vision of the future service; **[4]** Identify competencies; **[5]** Allocate competence to career framework level; **[6]** Identify and create new roles from competence; **[7]** Quality assure profiles; **[8]** Undertake training needs analyses; **[9]** Implementation – change management; **and [10]** Evaluation.

148. There is limited utility in simply describing the distribution of a workforce headcount and FTE, beyond a crude description of overall workforce capacity. Instead, workforce planning should be asking a) what is the local eligible need for service in a particular location? b) what specialist competencies and what generic

[136] NHS Wales, Competence Based Approach to Workforce Redesign <https://weds.heiw.wales/assets/Uploads/546f17e7ce/BCU-competence-based-brochure.pdf> [accessed 11 August 2020].

competencies are needed and at what volume to meet that need? c) where can those competencies be found and best harnessed in the existing workforce or in the untapped local labour market? d) what are the necessary strategies to build the requisite competencies in the available workforce? and; e) how can new workers with those competencies be sourced from education pipelines and other supply creation strategies? A range of techniques and strategies are available for undertaking these steps effectively.

149. Practice improvement to support Royal Commission recommendations can be thought of as having both technical and behavioural dimensions. This is described in the competency analysis and workforce development research undertaken by the Canadian Centre for Substance Abuse (**CCSA**). **Technical competencies** are the knowledge and skills required when applying specific technical principles and information in a job function. They are usually learnt in an educational environment or on-the-job. **Behavioural competencies** are the knowledge, skills and values required to perform effectively in a job function. They are typically learned through experience and represent how the job is to be performed. They complement the technical competencies. **The CCSA's framework organises both technical and behavioural competencies at stratified levels of proficiency against defined occupational clusters that describe key functional areas of service delivery** (also described as job families and job functions by the Australian Public Service Commission). Whilst not necessarily a methodology for workforce redesign in and of itself, tools like these that support competency analysis are critical for any redesign effort. Application tools derived from the CCSA technical and behavioural competency sets focus on a jurisdiction-wide and integrated approach to implementation through supporting the development of job profiles, competency-based training, competency-based interviewing, supervision practice, curriculum

development, clinician self-evaluation, employee performance reviews, and succession planning[137].

150. **A similar approach has been taken in Victoria by Family Safety Victoria (FSV) to support implementation of recommendations arising from the Royal Commission into Family Violence.** The development of a capability framework with detailed knowledge and skill indicators has been undertaken to create four tiers, ranging from generalist to specialist categories, with better outcomes for women and children driven through 'capabilities for high performance'. For the top specialist tier, four levels of proficiency are described, from entry level through to expert. Whilst the framework stops short of mapping high performance in each of its domains against specific service outcomes, it is underpinned by an understanding of the broader service and system reform agenda. It has been designed to support the development of job descriptions, career planning, identification of professional development and training needs, understanding and articulating career pathways for people in the discipline, and improving performance appraisal. Curriculum development for targeted professions is currently underway to embed essential capabilities in education pipelines. Whilst conceptually sound, there is no available research into the effectiveness of this or other capability frameworks to redefine and embed high performance in the workforce[138].

151. **Building new capabilities is no easy task**. Traditionally, workforce strategies have overly relied on education and training to improve the practice of professionals, but the research shows that this approach produces very modest

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[137] Canadian Centre on Substance Abuse, Competencies for Canada's Substance Abuse Workforce, 2014 <http://www.niagaraknowledgeexchange.com/wp-content/uploads/sites/2/2014/10/CCSA-Workforce-Competencies-Overview-2014-en.pdf>.

[138] Family Safety Victoria, Victorian State Government, Responding to Family Violence Capability Framework, December 2017.

results[139]. For example, in the available literature estimates of the exact extent of the transfer problem varies, from Georgenson's (1982)[140] estimate that 10% of training results in a behavioural change, to Saks' (2002)[141] survey data suggesting about 40% of trainees fail to transfer knowledge delivered in training immediately after; 70% falter in transfer one year after the program; and ultimately only 50% of training investments result in organisational or individual improvements. **The paucity of evidence about the role of training in practice change relates in part to methodological issues**. An evaluation of the implementation of the Queensland Mental Health Act (2016)[142] reported on the outcome of competency-based training, capacity assessment training and advance health directive training delivered through a combination of face-to-face learning and digital platforms. An evaluation focused primarily on self-reports of readiness prior to commencement of the Act demonstrated that only half of all respondents felt that education and training assisted them to feel moderately to well-prepared before the Act was implemented. The study did not examine practice or behaviour change arising from training, nor systematically investigate the complex interaction of individual and organisational factors in change management and clinical behaviour change. This is a common shortcoming in such studies.

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[139] Burke, L. A and Hutchins, H. M. 'Training transfer: An integrated literature review', *Human Resource Development Review* 6 (3) (2007), 263-296.

[140] Georgenson, D. L. 'The problem of transfer calls for partnership. Training and Development Journal', 36 (10) (1982), 75-78.

[141] Saks, A. M. 'So what is a good transfer of training estimate? A reply to Fitzpatrick',

The Industrial-Organizational Psychologist, 39 (2002), 29-30.

[142] Queensland Health, 'Evaluation of the Mental Health Act 2016 implementation: Evaluation Report', , https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/evaluation>.

152. An emerging body of research is investigating why knowledge acquired in training does not routinely find its way into everyday practice and what insights into human behaviour change can be applied to knowledge transfer for clinical practice change. An Australian study into knowledge transfer in mental health practice relating to the Collaborative Recovery Model reported that "a large body of multi-disciplinary research indicates disappointing rates of knowledge transfer" and investigated the purposeful and structured use of values-based interventions to facilitate increased autonomy as a means of promoting implementation of workplace change[143]. Rather than focusing on knowledge acquisition through education and skill development through training, this study explored **worker motivation** as a key mechanism for knowledge transfer using values-based coaching that included card sorting exercises to align 'life-in-general' values with 'workplace' values. It also examined transfer in the workplace in the context of implementation initiatives where workers are not 'volunteers' in requisite change processes. In a similar vein, **the Illawarra Institute for Mental Health has published intervention and coaching protocols that facilitate the transfer of collaborative recovery training into practice**[144]. The approach relies on techniques known as implementation coaching and transformational coaching and the protocols include detailed guidelines regarding capacity building and delivery of these approaches. What sets this apart is its focus on **values clarification and coaching** as an adjunct to training, rather than as an alternative.

153. **Another approach involves the recruitment and development of people whose personal beliefs and behaviours align with the competencies required to drive**

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[143] Williams et al. 'Improving implementation of evidence-based practice in mental health service delivery: protocol for a cluster randomised quasi-experimental investigation of staff-focused values interventions' *Implementation Science*, 8 (75) (2013), 1-10.

[144] Deane, F. P., Crowe, T. P., Oades, L. G., Ciarrochi, J., Marshall, S., Williams, V., and Andresen, R. 'Facilitating the transfer of Collaborative Recovery Training into Clinical Practice: Intervention and Coaching Protocols'. *Australia Illawarra Institute for Mental Health*, University of Wollongong (2010).

system transformation. Values-based recruitment (**VBR**) is one such approach being used in the National Health Service (**NHS**) England to help attract and employ prospective employees whose values align with those held by the NHS[145] [146]. Values are goals that influence behaviour and have a complex relationship with attributes such as personality, ability and motivation. To help in this process, the NHS has created resources, including toolkits and recruitment and behaviour frameworks[147]. **The recruitment framework describes a process** by which values are tested at multiple assessment points during planning a preparation for selection, marketing of careers to prospective candidates, screening and then selection. Post selection, the framework promotes evidence of values in education, training, development and organisational culture. Values are also embedded in organisational process and continuous learning and development[148]. Evaluation of this approach in the healthcare sector is in its infancy, though a range of benefits arising from this approach have been reported, including a reduction in agency spend and recruitment, a positive impact on staff turnover, improved staff morale, increased job satisfaction and provision of the best care possible to patients[149].

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[145] NHS Employers, 'Values Based Recruitment' <https://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/values-based-recruitment>.

[146] The NHS values are as follows: 1. Working together for patients; 2. Respect and dignity; 3. Commitment to quality of care; 4. Compassion; 5. Improving lives; 6. Everyone counts.

[147] NHS Employers, 'VBR Behaviour Framework based on the NHS Constitution', November 2014, 1-4. <https://www.nhsemployers.org/-/media/Employers/Documents/Recruit/VBR-Behaviour-framework-based-on-the-NHS-Constitution.pdf?dl=1>.

[148] Health Education England, Valued Based Recruitment Framework, October 2014, 1-103. <http://qna.files.parliament.uk/qna-attachments/385393/original/HEE-%20Value%20based%20recruitment%20framework%202014.pdf >.

[149] NHS England, 'Recruitment based on the NHS Constitution: Valued based recruitment', <https://www.hee.nhs.uk/our-work/values-based-recruitment> .

154. **These findings lead to the conclusion that workforce planning for appropriate supply, distribution and capability must have a focus on outcomes and implementation**. Knowledge and technical skill is important and can be sourced by recruiting more of the same kinds of clinical and non-clinical staff currently trained by universities and Technical and Further Education (**TAFE**) colleges and/or by redesigning the workforce to allow for the development of categories of mental healthcare workers with the competencies, proficiencies and expertise identified in collaboration with consumers, carers and technical experts. Changing the system for the better, however, could be achieved by training, coaching and recruiting to the values identified as reform priorities. The system must be supported in developing the tools and frameworks necessary to achieve these objectives and to ensure that learning and development is mobilised to embed the values sought in the new mental health system. Ultimately, in shaping the thinking and behaviour of staff, these efforts will also have an impact on organisational culture, a topic that was the focus of the discussion earlier in this witness statement.

7. CHALLENGES TO DELIVERING THE GROWTH AND DIVERSIFICATION OF THE WORKFORCE

155. With the changing needs of Victorian health care, and the move to person-centred care, it is important to ensure that the workforce is supported to effectively deliver the models of care and meet the needs and expectations of the community. I have already written about the importance of ensuring the goals and objectives of mental health reform are embedded and reinforced through the values and behaviours of the workforce. Large-scale, rapid system reforms within health are confronted by many challenges, particularly in relation to workforce resourcing and the sector's willingness to implement and sustain changes articulated at a policy level. **The personal and professional values of the workforce are integral to ensure a motivated and engaged workforce that can participate in and implement the reform agenda** and overcome a range of challenges, including:

a) **Insufficient staff numbers**. In a rapidly growing workforce, values-based workforce reform recommends looking at new avenues for recruitment, as well as strengthening the culture of organisations to increase staff retention and maintain staff numbers. This is achieved through ensuring cultural fit of employees that mirror the organisation's values and the objectives of the reform. Through values-based recruitment and reform, there are also opportunities to increase the diversity of the workforce by identifying values central to the concerns of targeted cohorts. The focus on values can be a supplement to accreditation.

b) **Insufficient time and resources to train and recruit**. Workplaces that operate on a values basis are better able to overcome the pressures of modern healthcare. In our health system, services are increasingly challenged by the need to improve care, improve health outcomes and do this at a lower cost. Employing staff who share a positive values system can assist in meeting these goals. With increasing budget constraints, training opportunities can be constrained, and instead upskilling needs to be

delivered differently. Employees with shared positive values are more receptive to peer-learning and on the job feedback as a method of upskilling, which can support existing moves to less formalised training options brought about by budget constraints and a focus on training outcomes. In addition, workplaces with strong values cultures are less likely to have issues with presenteeism and absenteeism, including high rates of sick leave, which further reduces capacity burdens on the workforce.

c) **Lack of skills**. Consumer and recovery-based care is central to the delivery of an effective mental health system. Central to the delivery of these practices is staff who are committed to delivering them. Where staff do not have the values of the organisation, culture and sector they work in, they are less capable of delivering the care that is expected of them by consumers, carers and colleagues.

d) **Negative work cultures**. Professional workplace cultures are built on the values and beliefs of the organisation and should be shared by the employees to motivate them to deliver the best professional outcomes. According to organisational culture theory, cultures control and influence behaviour-either for the better or worse. Mental health workplaces are no different and should identify key organisational and practice values. These values should reinforce behaviours that support the reform agenda, such as consumer-centred care, quality and safety, safeguarding and others that are determined by the organisation, consumers, carers and workforce, including a diversity of perspectives and disciplines.

156. However, values must be reinforced and demonstrated within workplaces. A values-based workforce requires that the leaders within mental health workplaces and the sector more broadly, exhibit and encourage the continuous challenge of living up to the values we set ourselves. Capable, inspiring, compassionate, responsive, innovative and values-based leaders are required to facilitate and drive reform in the sector. Leadership provides the direction and support to transition the workforce

towards the reform goals which are framed around their shared values. Without leadership and leaders that embody the values, the credibility of the reforms, and subsequently their delivery, suffers.

157. Other challenges to workforce diversification are regulatory and/or historical, such as restricting the qualifications required to work in mental health settings, even when potential employees may have the requisite capabilities required to work in broader settings. Values-based recruitment has been introduced in other jurisdictions to help overcome the challenge of an inadequate supply of employees in under-resourced areas such as mental health, which cannot afford to overlook potential well-suited workforce cohorts simply because they lack the approved qualifications. Values-based recruitment recommends the assessment of candidates' values in addition to their skills. For example, paramedics are a well-trained medical workforce with the right value set to work in mental health and could be a valuable resource pool, particularly given the oversupply of paramedic graduates in Victoria. However, the *Mental Health Act 2014*[150] defines mental health practitioners as registered psychologists, nurses, occupational therapists or social workers. It therefore does not support their deployment into mental health services with powers to act as mental health clinicians. The Act also limits the flexibility of other workforce pipelines with similar value, capacity, transferability and utility.

CHALLENGES TO ACHIEVING COLLABORATIVE, CROSS-DISCIPLINARY PROFESSIONAL PRACTICE

158. Each profession within Victorian mental health practice brings its own unique value, derived from discipline specific theories, frameworks and practices, and each faces challenges translating this unique value into service delivery. A forum involving allied health leaders from across the mental health sector and held by DHHS in

[150] *Mental Health Act 2014 (Vic).*

2017 identified a wide range of factors that constrain workforce and skills utilisation across the allied health professions including social work, psychology, occupational therapy and speech pathology[151]. In the consultation, participants revealed that the teaching of mental health competencies in undergraduate courses across disciplines is inconsistent. They stated that there is a lack of entry level positions for allied health graduates. They said that Victoria's case management model makes it difficult to balance generic and specific roles for each profession and that models of care in Victorian mental health services do not easily lend themselves to harnessing and applying discipline-specific skills. The workshop identified as a high priority the need to strengthen leadership in allied health mental health practice in order to prevent the loss of role identity and specialist skills. The expansion and strengthening of discipline lead positions, discipline-specific professional development and discipline supervision were required to strengthen multidisciplinary team functioning. This feedback very much echoes the messages that emerged from the survey of allied health practitioners at Alfred Health, which I wrote about earlier in this statement. The dominance of medical and nursing disciplines in clinical mental health services reported in these consultations leads to the conclusion that achieving collaborative cross-disciplinary professional practice requires allied health skills to be intentionally harnessed into mental health practice with clear purpose, both clinically and operationally. Clinical models of care must be adjusted in order to enable consumers and families to benefit from the full range of skills and competencies available to them. This in turn requires changes to resources and capacity, specifically to the funding models and performance measures that I wrote about earlier in this statement and that could identify, pay for and reward multidisciplinary outputs and their outcomes.

159. The availability of different professions across regions and settings also has a bearing on the formation of multidisciplinary teams. There is no doubt that essential

[151] Department of Health and Human Services, Statewide forum: Allied Health in Mental Health. 'Shape the future of your discipline', unpublished workshop, , 2017.

skills and experiences are readily found in all the relevant mental health disciplines and a system which restricts the effectiveness, input and leadership of one or more of these disciplines is selling itself and service users short. Workforce development needs to ensure that all elements of the workforce are distributed evenly across different geographical regions. Programs to fund universities and TAFE colleges to create supply across different geographical regions of the State and to provide placements in regional hospital and community services must be ramped up. Opportunities must also be created in different settings. Multidisciplinary practice looks different in Child and Adolescent settings (with a greater representation of psychologists, occupational therapists, speech therapists and social workers) than in inpatient mental health units. Services that require round the clock staffing tend to have a greater representation of mental health nurses to work outside normal working hours. Industrial awards for medical and allied health professions make it more expensive to roster those professional groups after business hours, meaning that for the major part of the week, such services are staffed by nurses. This impedes the multidisciplinary ethos. Steps should be taken to facilitate the presence of allied health practitioners in hospital and emergency services seven days a week. This will ensure allied health interventions are carried out after hours, and in particular on weekends when patients in my experience complain of having less to do, and working families are often more available.

160. The Irish Mental Health Commission has suggested that collaborative working is itself a specialist skill and building this capability is as important as training in discipline specific skills[152]. This capability is required at the worker, team and organisational levels in order to manage a range of multidisciplinary team issues that includes:

[152] Mental Health Commission Ireland, 'Multidisciplinary team working: From theory to practice', Discussion paper (2006), Mental Health Commission, Dublin, Ireland.

a) **Team formation and implementation**, with a clear focus on the competencies required to meet service needs (as outlined above) and shared values;

b) **Leadership**, including the model of decision making and how the team is guided towards broadly based clinical assessments and delivery for best mental health care;

c) **Management**, with a focus on practice standards, policies and procedures, and staff support and development;

d) **Training**, across legislative, organisational, medication, operational policies, risk management knowledge and skills;

e) **Conflict management**, arising from different ideas, goals, values, beliefs and needs across the team;

f) **Supervision**, with a focus on maintaining professional skills through access to discipline seniors and supervisors;

g) **Accountability**, within a clear definition of clinical accountability and clarity of roles and responsibilities across the team and identification of boundaries of accountability;

h) **Confidentiality**, in the context of continuity of care, working with families and carers, clinical boundaries relating to lived experience workforces; and

i) **Team policies**, that are documented and designed to manage the above and other issues.

161. In my clinical experience, as the system has become increasingly under-resourced, focused on access and risk, and reliant on a part-time nursing, allied health and

senior medical workforce, expertise in collaborative practice has become a growing deficit. The increased clinical activity and reliance upon a part-time workforce has meant less time and opportunity for the multidisciplinary meetings that provided the opportunity to hear diverse views and work through complexity. This deficit is most apparent in the hospital setting. The shift to digital technologies could create opportunities to do this differently.

162. Limiting workforce planning to under-supplied and over-strained professions runs the risk of missing the opportunity for workforce innovation that sits at the nexus of consumer needs, outcomes, competencies and new service delivery functions. Health workforce planning forecasts indicate that service delivery demands in primary and acute health and the community sector will place increasing pressure on shortfalls for psychiatry[153], mental health nursing[154] and allied health workforces, and that will create competition with mental health for short supply, even within current service configurations and models of care.

163. The emergence of the lived experience workforce has allowed the identification of previously absent functions that peer support and consumer and carer consultants now perform ably. It is entirely possible that system reform will require new functions that are currently absent, and both models of care and workforce design issues will need to contend with that. People with lived experience have been employed in Victoria's mental health system since 1996, with an early emphasis on quality improvement and more recently, in peer support roles in both community and inpatient settings[155]. Throughout this time, lived experience positions have

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[153] Department of Health, Australia's Future Health Workforce – Psychiatry, March 2016. <https://www1.health.gov.au/internet/main/publishing.nsf/Content/597F2D320AF16FDBCA257F7C0080667F/$File/AFHW%20Psychiatry%20Report.pdf>.

[154] Health Workforce Australia, Australia's Future Health Workforce: Nurses - Detailed Report, August 2014, 52.

[155] Department of Health and Human Services, Lived experience workforce positions in Victorian public mental health services, 2017.

often practiced in isolated and fragmented ways due to a lack of organisational and clinical integration with mainstream programs and team structures. In its Interim Report, the Royal Commission has stressed the need for greater organisation readiness to best utilise the unique skills offered by the lived experience workforce, with an appreciation of the cultural shift that is needed to embrace this emerging workforce as a core mental health workforce. Most significantly, the Interim Report indicates that system reform will involve new models of care, and that growth in the lived experience workforce will be needed for them play an increasingly central role in the delivery of these models. Multidisciplinary teams must be clear about how practices such as Intentional Peer Support are embedded in these teams and how teams need to respect and embrace lived experience practices as new mental health discipline alongside their own. This is a priority program of work for MHRV.

NEW ROLES IN MENTAL HEALTH

164. Introducing new roles in mental health can help to reduce workforce shortages and improve service outcomes, by maximising skill utilisation in the current mental health workforce and attracting workers from non-traditional sources. Arguably, public mental health has been slow to reinvent its workforce around a changing service delivery paradigm as it transitioned from institutional care to community-based care, which has redefined person-centred, family-inclusive and recovery-oriented care in mental health practice. Mental health in Victoria, indeed Australia, has not really opened the sector to new professions far beyond the five main professions originally prescribed in the National Mental Health Practice Standards[156]. Although the concept of allied health in mental health has expanded to include speech pathologists and to a limited extent exercise physiologists and dieticians, it remains primarily concerned with social work, occupational therapists

[156] Victorian Department of Health on behalf of the Safety and Quality Partnership Standing Committee, 'National Standards for the Mental Health Workforce', <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-wkstd13-toc>.

and psychologists. Looking further afield can address skill gaps needed for contemporary multidisciplinary mental health practice. In recent years a range of new roles have been introduced in mental health in Australia with these aims. Examples include nurse practitioners, clinical nurse consultants, psychotherapists, counsellors, and New Access coaches.

165. Nurse practitioners were first introduced in 2001 in Australia and work in a range of practice areas including mental health. The national nurse practitioners' standards for practice specify that nurse practitioners assess patients, apply diagnostic capability, plan care, engage others, prescribe and implement therapeutic interventions, evaluate outcomes and improve practice[157]. The role includes responsibilities which have traditionally been undertaken by doctors, especially the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. A study of nurse practitioner services in an Australian mental health outpatient clinic found statistically significant reduction in psychological distress after attending the clinic, with some improvement in the mean score for the self-efficacy scale. In general, patients were very positive about aspects of the service, particularly availability, accessibility and therapeutic features[158]. This was consistent with findings from a study of nurse practitioners in an emergency department which found that certain aspects of patient care (having enough time to discuss things, provision of instructions for follow-up care) were viewed more favourably by those whose care had been managed by nurse

[157] Nursing and Midwifery Board, AHPRA, 'Nurse practitioner standards for practice' <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/nurse-practitioner-standards-of-practice.aspx> [accessed 11 August].

[158] West T et al. 'Outcomes from the evaluation of an emergency department-based mental health nurse practitioner outpatient service in Australia', *Journal of the American Academy of Nurse Practitioners* 24 (3) (2012), 148-159.

practitioners compared to those managed by doctors[159].Key issues affecting successful implementation of nurse practitioner positions include clarity regarding the role and reporting line of the nurse practitioner, strong collaborative relationships, particularly with medical staff, and the support of managers, doctors and other nurses[160].

166. Clinical nurse consultants have been funded by DHHS since 2018-19 to provide mentorship and clinical expertise to address priority issues such as consumer and staff safety and to support vulnerable service users with high needs. The consultants are intended to support a better service experience for consumers and carers and to lead implementation of priority reforms. Twenty-five positions are funded in 2019-20, which will increase to 31 in 2020-21. Evaluation of the initiative is underway, with initial findings that the consultants have reduced the incidence of occupational violence and increased staff satisfaction. Implementation challenges have included finding staff with suitable skills and experience and providing role clarity within existing organisational structures.

167. The broader school of therapists that includes family therapists, psychotherapists and counsellors and others who deliver evidence-based recovery-oriented care appears to be an overlooked source of talent for mental health. The Psychotherapy and Counselling Federation of Australia (**PACFA**) advocates for the inclusion of Registered Counsellors and Psychotherapists in federal, State and territory mental health legislation and in mental health workforce datasets, frameworks and

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[159] Dinh M, Walker A, Parameswaran A, Enright N. 'Evaluating the quality of care delivered by an emergency department fast track unit with both nurse practitioners and doctors', *Australasian Emergency Nursing* Journal 15 (4) (2012),188–194.

2. [160] Torrens C et al. 'Barriers and facilitators to the implementation of the advanced nurse practitioner role in primary care settings: A scoping review', *I College of Nursing Australiasia*, 104 (2020); 103443.

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strategies, and for recognition of Counsellors and psychotherapists as skilled and qualified service providers in a variety of government funded initiatives[161]. I am supportive of this, and I believe that in well-funded community mental health system, there would be significant opportunities for such a workforce to support the mental health needs of the population. The headspace primary centres have routinely included counsellors and psychotherapists among the private practitioners contracted to provide services. Although there is no outcome data available for this practice in this setting, feedback from youth and their families has been no different to that provided in relation to the clinical professions. A barrier to employing psychotherapists and counsellors has been the perception that they are not trained to treat mental illness, as such. In a well-resourced mental health system, this challenge could be overcome with appropriate triage or intake and by embedding workers in clinical teams with supervision, and escalation protocols.

168. New Access is a recent initiative which aims to expand the availability of low intensive mental health support, particularly to demographic groups which with relatively low access to more traditional services. The service provides up to six sessions of cognitive behavioural therapy and is currently delivered by 12 Primary Health Networks in eastern Australia. New Access coaches undertake 12 months of training, starting with a six-week intensive followed by practical learning which involves managing clients and an ongoing curriculum under clinical supervision. Coaches are not required to have prior mental health training, providing the opportunity to develop a new workforce to support people experiencing mild to moderate depression and/or anxiety. Clients identified as needing more support or a different type of support are referred to other services[162]. An evaluation found the

[161] Psychotherapy and Counselling Federation of Australia, 'PACFA response to the Productivity Commission's draft report on mental health', <https://www.pacfa.org.au/pacfa-response-to-the-productivity-commissions-draft-report-on-mental-health/>.

[162] Beyondblue, 'About NewAcess' <https://www.beyondblue.org.au/get-support/newaccess/about-newaccess>.

program had positive results, with 67.5 per cent of clients who entered the program with rating scores above the clinical cut off, leaving the program with rating scores below the cut off. It also found that 'the Access Coach role represented a new workforce which, though small, appeared to be stable, with capacity to become part of the continuum of mental health workforce in Australia…The role was attractive to those seeking a career pathway in mental health and those wanting to remain as coaches[163]. The evaluation found that critical success factors included 'embedding the program within the health and social care systems', 'recognising the place of the program in a stepped care mental health system', 'maintaining current processes to support fidelity, and manage clinical risk' and 'positioning the Access Coach in the Australian mental health workforce, accredited training and developing career pathways' (page 8).

169. Alfred Health introduced support worker positions into its Hospital Outreach Postsuicidal Engagement (**HOPE**) team in 2018. Support workers are typically health graduates without relevant mental health clinical qualifications, such as youth work, community services or counselling psychology. Many have embarked upon clinical qualifications during their employment with the HOPE team. Their role is central to the effectiveness of the team. Consumers of the HOPE service work on what is important to them. Their goals do not always directly concern their mental health, but typically include goals that derive what might be referred to as social determinants that impact upon mental health, such as issues with housing, income, family or substance misuse. Interventions therefore must be practical, flexible and focused on the well-being of the client. Support workers offer emotional and practical support and work with senior mental health clinicians with flexibility. Rapid escalation pathways to clinicians ensure that clinical support is mobilised to meet the needs of consumers when this be required. Support workers are provided with

[163] Beyondblue New Access Demonstration Independent Evaluation: Summary of Findings. Ernst and Young, 2015 < https://www.beyondblue.org.au/docs/default-source/research-project-files/bw0353_beyondblue-newaccess-demonstration-independent-evaluation.pdf?sfvrsn=7e1050ea_0>.

regular supervision by clinicians. This allows expertise to be built and ensures that well-being is maintained. An evaluation of the HOPE service in 2020 showed that 53% of the contact hours provided by this team were delivered by support, as opposed to clinical healthcare workers. The feedback from consumers rated the support of support workers as highly as that of clinicians. Continuity of care and availability are the features most highly valued[164].

170. In summary, there is significant scope for new roles in mental health services. Nurse practitioners, clinical nurse consultants, mental health workers with training in specific interventions or support workers with non-clinical health qualifications working under the supervision of clinicians have all been deployed successfully, with evaluation indicating that they have been highly valued by consumers and carers and have provided effective services. Role clarity and reporting lines are essential to success, by ensuring support from the existing workforce, principally management and medical staff; and by facilitating the development of strong collaborative relationships between disciplines. The development of competencies for structured and social interventions, delivered by non-clinicians under supervision offers an especially interesting pathway for mental health services to consider as the system expands to serve a larger proportion of the population in the community and the needs of people with mild to moderately severe mental health problems.

[164] White A et al. 'Inspiring HOPE: measuring the engagement and impact of the first two years of the Alfred Hospital Outreach Postsuicidal Engagement (HOPE) program'. *Alfred Health and Swinburne University of Technology* 2020.

8. EMERGING CHANGES IN HEALTH SERVICE DELIVERY, INCLUDING MENTAL HEALTH SERVICE DELIVERY, AS A CONSEQUENCE OF COVID-19

171. Since the declaration of the public health emergency on 16 March 2020, it has become apparent that changes in the way in which some mental health services are provided have taken place. Some of these have created enormous flexibility for consumers, families and clinicians and improved the experience of care. They should be retained even after the pandemic is over. It is also evident that the Commonwealth and Victorian policy response to COVID-19 in promoting mental health outcomes as a health sector priority will support the objectives of mental health reform in future.

172. The long-term consequences of COVID-19 are yet to unfold, but the possibilities emerging signal a period of deep uncertainty ahead for social cohesion, mental and emotional wellbeing, and global security [165]. As COVID-19 has spread across Australia, our health system has appropriately prioritised the treatment of respiratory illness and scaled up critical care capacity to an unprecedented level[166]. Beginning in March 2020, accounts started to appear about the impact of the pandemic on **patients with existing mental illness** and **mental healthcare systems** in affected countries where containment had failed; first in China[167] and

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[165] Goldin I and Muggah R, The Conversation 'The world before this coronavirus and after cannot be the same',. 28 March 2020 < https://theconversation.com/the-world-before-this-coronavirus-and-after-cannot-be-the-same-134905>.

[166] Meares HDD and Jones MP. 'When a system breaks: a queueing theory model for the number of intensive care beds during the COVID–19 pandemic', *The Medical Journal of Australia* 212 (10) (2020), 470-471.

[167] Yao H, Chen JH and Xu YF. 'Patients with mental health disorders in the COVID–19 epidemic', *The Lancet Psychiatry* 7 (4) (2020), 21.

Iran[168]; and later, Italy[169], Spain[170] and the USA. Patients with existing mental illness were at high risk of contracting COVID-19, especially if living in residential or supported care facilities[171]. **Common practice changes were recorded in several jurisdictions**. In high income countries with an advanced telecommunications infrastructure, digital platforms became widely used in outpatient mental health settings[172] [173]. In jurisdictions where community spread was high, access to inpatient units (**IPUs**) was compromised by bed closures arising from the combined effects of outbreaks in the IPUs; staff illness and exposure; and the demand for healthcare workers by units treating respiratory cases[174]. Operational instructions providing guidance for the safe screening and management of patients in hospital and community settings emerged[175] [176].

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[168] Zandifar A and Badrfam R. 'Iranian mental health during the COVID–19 epidemic' *Asian Journal of psychiatry* 51 (2020) June.

[169] Percudani M, Corradin M, Moreno M, Indelicato A, Vita A. 'Mental health services in Lombardy during COVID-19 outbreak' *Psychiatry research* 288 (2020);: 112980 <https://doi.org/10.1016/j.psychres.2020.112980>.

[170] Arango C. 'Lessons learned from the coronavirus health crisis in Madrid, Spain, how COVID-19 changed our lives in the last two weeks' *Society of Biological Psychiatry* (2020).<https://doi.org/10.1016/j.biopsych.2020.04.003>.

[171] Druss BG. 'Addressing the COVID–19 pandemic in populations with serious mental illness'. *JAMA Psychiatry,* (2020) <https://doi.org/10.1001/jamapsychiatry.2020.0894 >.

[172] Zhou XY, Snoswell CL et al. 'The Role of Telehealth in Reducing the Mental Health Burden from COVID-19'. *Telemedicine and e–health*, 26 (4) (2020), 377-379 <https://doi.org/10.1089/tmj.2020.0068 >.

[173] Corruble E. 'A viewpoint from Paris on the COVID–19 pandemic: a necessary turn to telepsychiatry', *Journal of Clinical Psychiatry*; 81 (3)(2020), 1 <https://doi.org/10.4088/JCP.20com13361>.

[174] Fagiolini A, Cuomo A and Frank E, 'COVID-19 Diary from a Psychiatry Department in Italy' www.nlm.ncbi.unboundmedicine.com.

[175] Starace F et al. 'COVID-19 disease emergency operational instructions for Mental Health Departments issued by the Italian Society of Epidemiological Psychiatry', *Epidemiology and Psychiatric sciences* 29 (116) (2020), 1– 12. https://doi.org/10.1001/jamapsychiatry.2020.0894.

173. The vulnerability of **specific groups with no prior history of mental illness** to mental distress as a result of the COVID-19 pandemic also became a focus of interest. During and after the SARS epidemic in Hong Kong, healthcare workers and recovered patients were observed to be at increased risk of psychological distress following experiences of illness, near death, loss, isolation and quarantine[177]. The COVID-19 pandemic was expected to have a similar effect. Concerns about rising community rates of suicide in vulnerable groups such as the elderly also emerged, and a tsunami of mental illness was predicted[178]. Three areas of concern came under particular scrutiny:

a) **People infected by coronavirus**. Studies indicated both short- and long-term mental health effects on patients infected during the pandemic. In Wuhan, a study of 730 COVID-19 patients who had been clinically stable and admitted to hospital without requiring intensive care treatment, found significant post-traumatic stress symptoms as measured by the 17–item self-reported PTSD checklist (PCL-C) in 96.2% of the sample[179]. In Hong Kong, a study of a sample of people who survived infection with SARS in 2003, found that 29% had a diagnosis of PTSD or depression thirty months after infection[180].

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[176] Royal College of Psychiatrists, 'COVID-19: Community mental health settings' <https://bit.ly/3clrdBq>

[177] Maunder R, 'Was SARS a mental health catastrophe? Editorial', *General Hospital Psychiatry* 31 (2009), 316-17.

[178] Torjesen I, 'Covid-19: mental health services must be boosted to deal with "tsunami" of cases after lockdown' *British Medical Journal* 369 (8246) (2020).

[179] Bo, H., Li, W., Yang, Y., Wang, Y., Zhang, Q., Cheung, T., Xiang, Y. 'Posttraumatic stress symptoms and attitude toward crisis mental health services among clinically stable patients with COVID-19 in China' *Psychological Medicine*, (2020), 1-2 <https://doi.org/10.1017/S0033291720000999>.

[180] Mak IWC, Chu CM, Pan PC, Yiu GC, Lee VL, 'Long-term psychiatric morbidities among SARS survivors', General HospitalPsychiatry,31 (4) (2009), 318-26.

b) **Healthcare workers**. Similar findings of mental health sequelae were found in healthcare workers exposed to the pandemic. Being quarantined was significantly and positively associated with stress-related disorders and avoidance behaviours, such as minimising direct contact with patients and not reporting to work[181]. Exposure to infected patients in the course of clinical work was also associated with increased mental distress. A study of 994 doctors and nurses in Wuhan China, found that 22.4% had moderate and 6.2% severe mental health disturbances as measured using the Patient Health Questionnaire (PHQ-9) in the immediate aftermath of the epidemic[182].

c) **Suicide**. SARS in 2003 was associated with a 30% increase in suicide in those aged 65 years and older[183]. This may have been a phenomenon unique to Hong Kong. A study was conducted into the effect of natural disasters on suicide in the USA in 377 counties affected between 1982 and 1989[184]. Data was collected over three years before and four years after the index event. The initial finding that suicide rates increased after earthquakes, floods and hurricanes was retracted the following year when a follow up analysis showed no change in suicide rates[185]. The link with

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[181] Brooks, Samantha K et al, 'The psychological impact of quarantine and how to reduce it: rapid review of the evidence', *The Lancet,* 395 (10227) (2020), 912 – 920..

[182] Kang, L., Ma SM, Chen, M., Yang, J, Yang, Y et al., 'Impact on mental health and perceptions of psychological care among medical and nursing staff in Wuhan during the 2019 novel coronavirus outbreak: a cross-sectional study' *Brain, Behaviour, and Immunity,* 87 (2020), 11-17 < https://doi.org/10.1016/j.bbi.2020.03.028>.

[183] Yip PS, Cheung YT, Chau PH, Law YW. 'The impact of epidemic outbreak: the case of severe acute respiratory syndrome (SARS) and suicide among older adults in Hong Kong' *Crisis* 31(2) (2010), 86–92.

[184] Krug EG et al. 'Suicide after natural disasters', *The New England Journal of Medicine* 338 (6) (1998), 373-378.

[185] Krug EG et al. 'Retraction: Suicide after natural disasters' *The New England Journal of Medicine,* 340 (2) (1999), 148-149.

suicide is likely to be complex, associated with the duration of the pandemic and its impact on social connectedness and loneliness, and mitigated by a range of social and economic interventions.

174. There is ample evidence that disasters, epidemics and economic downturns are associated with mental health sequelae in affected populations. Guidance from WHO and other sources highlighted the importance of public health measures to mitigate the mental health impact of the pandemic on populations. These included a whole-of-population approach to the *mental health needs of the community*, for example through support of remote learning for children and domestic violence initiatives; *widespread emergency mental health and psychosocial support*, for example by enhancing social connection for elderly persons, or investing in telehealth counselling services; and *mental health reform* and using interest in the mental health impacts of the pandemic to motivate the community to "build back better" a mental health system accessible to all[186]. Clear unambiguous public health information is recommended to reduce population stress and anxiety and enhance public engagement with the difficult task of containment and mitigation[187], as are essential services/commodities and financial support to citizens[188].

175. In Victoria, it became evident early on in our pandemic preparation that our ability to provide services to people with severe mental illness could be compromised in the event of substantial community transmission. Victoria serves approximately 75,000 registered clients in its public mental health system. These include clinical

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[186] United Nations, Policy brief: COVID–19 and the need for action on mental health, 13 May 2020 <https://www.un.org/sites/un2.un.org/files/un_policy_brief-covid_and_mental_health_final.pdf>.

[187] Torales J, O'Higgins M, et al. 'The outbreak of COVID–19 coronavirus and its impact on global mental health' *International Journal of Social Psychiatry*,March 2020, 1-4 < https://doi.org/10.1177/0020764020915212>.

[188] Wang CY, Pan R, Wan X et al, 'A longitudinal study on the mental health of general population during the Covid-19 epidemic in China. Brain, behaviour, and immunity' *Science Direct*, 87 (2020), 40-48 <https://doi.org/10.1016/j.bbi.2020.04.028>.

and support services; provided by health and non-government organisations; funded by the Victorian and Commonwealth governments; and not including primary and specialist care funded through the Medicare Benefits Scheme. The RCVMHS had already established prior to the pandemic that the system did not broadly meet the needs for treatment of mental health issues in the community, or the demand for hospital and emergency treatment of mental illness and psychological crises including suicide more specifically. Any further compromise in capacity would be of great concern to the viability of the system. We also knew from the experience of colleagues in Hong Kong during the first SARS epidemic in 2003 that the demands of pandemic containment and mitigation and post pandemic preparedness and prevention could result in a shift of attention away from concerns about mental health and wellbeing[189] and threaten the reforms being undertaken as a result of the RCVMHS, and the Commonwealth Productivity Commission into Mental Health.

176. In order to ensure an integrated response to the impact of COVID-19 on Victoria's Mental Health System, MHRV and the Mental Health and Drugs Branch (**MHDB**) in DHHS formed a partnership just after the state of emergency was called, called the *COVID-19 MH Response and Recovery Team* (**MHRRT**). Its aims were to:

- Support the continued provision of safe and high-quality mental health services during the pandemic in Victoria's Mental Health System.

- Guarantee that there was 'one entry' point to DHHS for the mental health sector and that learnings from responses to the pandemic could be shared across the system.

[189] Chiu HFK, Lam LCW, Li SW and Chiu E. 'SARS in psychogeriatrics – perspective and lessons from Hong Kong', *International Journal of Geriatric Psychiatry* 18 (10) (2003), 871 – 873.

- Issue communiques in which key sector issues and risks could be summarised, documented, and addressed.

- Ensure that changes to practice and system design that emerged as a result of COVID-19 were consistent with the objectives of the Interim Report of the RC-VMHS.

177. **Six principles were developed to guide the advice provided to Victoria's mental health sector by the COVID-19 MH Response and Recovery Team.**

a) **The response of Victoria's mental health services to the COVID-19 pandemic will be managed by health service and organisational governance processes and informed by the** *State Health Emergency Response Plan*[190]**, the** *COVID-19 Pandemic Plan for the Victorian Health Sector (2020)*[191] **and the** *Mental Health Act (2014)*[192]**.** In Victoria's health system, devolution of responsibility for the safety and performance of health services to local health authorities means that the work of pandemic preparedness for mental health services must be directed by the health services and non-government organisations that manage Victoria's public mental health services. Accountability for decisions regarding clinical practice, disability support, infection control, operational constraints and workforce availability is to the boards and chief executives of health services and non-government agencies. The role of the MHRRT would be to ensure that a system view was applied to changes and adjustments in processes, protocols and innovative models of care.

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[190] Emergency Management Victoria, ' State Health Emergency Response Plan Edition 4', 2017.

[191] Department of Health and Human Services, ' COVID-19 Pandemic Plan for the Victorian Health Sector', 2020 <https://www2.health.vic.gov.au/about/publications/ResearchAndReports/covid-19-pandemic-plan-for-vic>.

[192] *Mental Health Act 2014 (Vic).*

b) **Changes in the delivery of mental health services should reflect the principles underpinning the recommendations of the Interim Report of the RCVMHS (2019).** Given that Victoria is seeking to reform its mental health system in the long term, it is important that the choices made by service providers during the pandemic are consistent with the recommendations of the Royal Commission.

c) **Victorian mental health services will maintain essential clinical and psychosocial care that is equitable, accessible, appropriate and effective.** Mental health services must remain open for business, even if it cannot be business as usual. People and their families living with mental illness and alcohol and other drug (**AOD**)-related conditions are among the most vulnerable members of the community. They will be at heightened risk during the COVID-19 pandemic and are entitled to the same level of care of their mental and physical health as the general population. They and the Victorian community more broadly will require enhanced support of their social, cultural and emotional needs in the context of rising unemployment, physical distancing and the risk of social isolation and loneliness. Their needs must not to be neglected during the pandemic.

d) **Partnership and collaboration will underpin mental health services provided to consumers, carers and families.** When decisions about healthcare are taken rapidly in a public health emergency, the people affected by those decisions may not participate in the process. This may be necessary but should not persist for longer than the least amount of time required by the immediate needs of the emergency. Given that the pandemic is expected to persist for months if not years, systems must be developed to involve mental health consumers and their families, clinicians, and peer workers, in the development of care plans, the implementation of clinical decisions and changes to the ways in which care is provided. Changes to service delivery must be undertaken in collaboration with

clinicians and people with lived experience of mental illness. Co-design and co-production should be sought when possible.

e) **Innovation in the delivery of mental health services and implementation of alternate models of care will be required to ensure business continuity and maintain safety for clients, carers and clinicians.** The prevalence of mental illness and AOD disorders is likely to increase during and after the pandemic. Clinical and psychosocial services provided to individual consumers and carers must be shaped by the structured screening of patients for risks related to mental illness, AOD disorders and COVID-19.

f) **Difficult decisions about access, treatment and safety will need to be made by service providers in Victoria's MHS, working with consumers and their families during the** COVID-**19 pandemic.** These must balance clinical need, and the risks to the mental and physical health of consumers, families and clinicians. Services are encouraged to consider seeking guidance from Ethics Panels or Committees, which include people with lived experience as members.

178. Several trends or changes have emerged early in the pandemic response.

DATA REPORTING

a) Data is being collated by the Victorian Agency for Health Information (**VAHI**) about the impact of COVID-19 on mental health service utilisation. A report has been published each week since the beginning of May and provides an overview of demand in the hospital and community clinical sector, and in the community specialist NGO sector. The data includes emergency department presentations; mental health triage service presentations; consumers accessing clinical mental health services; bed-based clinical mental health services; community-based clinical mental health services; mental health

community support services; alcohol and other drug treatment services. Further work is being undertaken to incorporate activity in the Commonwealth-funded sectors including PHN-commissioned services, MBS-funded services and telephone counselling services. This report represents a welcome step forward in the analytic capacity of the sector. The long-term ambition is to be able to provide regional data for use by partner mental health agencies covering all elements of publicly funded mental health service provision.

b) The data shows that between March-May 2020, fewer new consumers have accessed public clinical mental health services and fewer presentations for care had been recorded by mental health triage and emergency departments for management of mental health, self-harm, and addiction-related issues. In early June 2020, the number of suicide deaths over the previous three months was within the range seen in the previous year[193]. At the same time, emergency mental health presentations were still 5.3% below levels seen at the same period last year (**SPLY**). The number of intentional self-harm presentations was 10.4% below SPLY; AOD presentations to ED was 7.0% below SPLY; mental health triage episodes was 4.7% below SPLY; new consumers accessing MHS was 14.3% below SPLY; admissions to an acute MH inpatient unit all settings was 2.6% below SPLY; number of new clients accessing AOD treatment services was 36.7% below SPLY; rates of seclusion were up 15.1% SPLY. Interestingly the number of ambulatory service contacts was up 9.8% on SPLY[194].

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[193] Victoria Agency for Health Information 'Impact of COVID-19 on mental health services in Victoria. Preliminary measures of access, activity and outcomes', 2020. Reports will be commencing 18 May 2020.

[194] Victoria Agency for Health Information 'Impact of COVID-19 on mental health and alcohol and other drug treatment services in Victoria', 2020.

Royal Commission into
Victoria's Mental Health System

INTENSIVE COMMUNITY MODELS OF CARE

a) A concern at the beginning of the pandemic was that IPUs would not be able to maintain access for patients in the event of a significant rise in the prevalence of COVID-19 in the community[195]. The potential for this outcome was dramatically illustrated by the Albert Road Clinic outbreak which resulted in the temporary closure of the clinic on the 27 April 2020[196]. Many AMHS undertook work to develop models for inpatient psychiatric care in order to minimise this risk. This typically involved segregating or cohorting vulnerable patients, in separate spaces for COVID-19 infected patients, suspected COVID-19 infected patients and uninfected patients. Given the very low numbers of community cases, most cases of suspected infection were managed within single rooms.

b) The COVID-19 MHRRT undertook to engage services in an exploration of possible models of intensive community care as a substitute for hospital inpatient care in the event of an outbreak. A guideline titled, "Providing acute mental health care in the community: intensive mental health community care. Coronavirus response" was published on 22 April 2020[197]. Its purpose was to identify available tools to enable services to adapt service delivery in response to demand surges and coronavirus (COVID-19) safety

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[195] Masha Gessen, The New Yorker, 'Whether psychiatric wards are uniquely vulnerable to the coronavirus', ; April 21 2020.

[196] Melissa Cunningham, The Sydney Morning Herald, 'Psychiatric clinic shut and patients moved to The Alfred following COVID-19 outbreak', 27 April 2020 <https://www.smh.com.au/national/psychiatric-clinic-shut-and-patients-moved-to-the-alfred-following-covid-19-outbreak-20200427-p54nhw.html>.

[197] Department of Health and Human Services, ' Providing Acute Mental Health Care in the Community – Intensive Mental Health Community Care coronavirus COVID19 response' <https://www.dhhs.vic.gov.au/sites/default/files/documents/202005/COVID-19-Intensive%20Mental%20Health%20Community%20Care-20200422.pdf>.

requirements; articulate the requirements to enable safe multidisciplinary Intensive Mental Health Community Care, as an alternative to inpatient mental health care; and promote working in partnership with consumers and their families/carers, clinicians, peer workers, GPs, private specialists and relevant NGOs and NDIS providers. As of June 2020, there had not been the expected surge of infections and the impetus for exploring intensive community treatment as an alternative to inpatient care had not yet emerged. That said, at least one service had implemented intensive community care as an alternative for a mother-baby unit with great success. Another major metropolitan mental health service was actively exploring the conversion of 8 beds to an intensive community model but had not yet implemented it. We know from experience during the pandemic in the provision of geriatric medicine, rehabilitation, general medicine and some specialty services that the shift from bed-based care to hospital in the home improved convenience and access for some patients. We believe that the same could apply for mental health patients. Hospital in the Home (**HiTH**) could present an alternative for patients who are safe to return home but need the intensive diagnostic, treatment and recovery services that can be provided by a multidisciplinary team through frequent home visits. This is a hypothesis that we will able to explore with establishment of HiTH at Barwon Health and Orygen through the acute bed expansion initiative being implemented by MHRV.

NATIONAL COLLABORATIVE MENTAL HEALTH RESPONSE

179. In response to the COVID-19 pandemic, governments across Australia have shown a commitment to addressing its mental health consequences and by extension the associated social determinants. The "National Mental Health and Wellbeing Pandemic Response Plan" published in May 2020 outlined the principles, priorities

and immediate actions for government[198]. Four of the seven foundation principles touched upon social determinants, namely **participation of consumers and carers** in all aspects of leading, designing and delivering responses; **partnership and collaboration across health and other sectors and communities** to deliver cohesive and coordinated care and support; **an integrated approach** to social and emotional wellbeing that considers the role of social determinants, environment and trauma in the causes of and responses to mental ill health; and **equity and equality** through a rights-based approach. The immediate priorities identified included data and modelling of the mental health impact of COVID-19, access to more flexible, intensive models of mental health care in the community and improved service linkages.

[198] National Mental Health Commission, 'National Mental Health and Wellbeing Pandemic Response Plan' <https://www.mentalhealthcommission.gov.au/Mental-Health-and-Wellbeing-Pandemic-Response-Plan#:~:text=The%20total%20response%20called%20for,a%20result%20of%20the%20pandemic>.

TELEHEALTH

181. **Since the emergence of the pandemic, telehealth has been established as a critically important enabler of clinical mental healthcare in the community**[199]. The Australian government introduced new temporary MBS telehealth items for mental health treatment in the community, due to expire on 30 September 2020. This important first step towards adoption of telehealth received widespread support from industrial bodies and the professional colleges. The take up of these items was rapid and extensive, such that the private psychiatrists and psychologists with whom I have contact tell me that between 40-100% of their outpatient work is now done using telehealth. At the same time, a similar transformation took place in public mental health services, supported by the publication of a guidance by DHHS[200]. Funding arrangements were never a barrier to implementation of telehealth in this sector, in contrast to the private MBS-funded sector, given that payment for services was not dependent on whether clinicians provided face-to-face services. Nevertheless, there was a reluctance on the part of health services in Victoria to adopt digital technologies in the delivery of direct patient care. Even when interest was high, most health services did not have the IT infrastructure, including bandwidth and devices, to facilitate this shift in practice. At the time of writing, I had spoken personally to clinical and/or operational directors from every area mental health service since the middle of March 2020, and each had advised me that most planned public mental health service contacts not requiring a physical intervention in the community (such as administration of an injection or physical examination) is now being undertaken by telephone or videoconference. VAHI data indicates that as of 22 May 2020, the latest 30-day average for the number of direct

[199] Melissa Sweet, Croakey, ' Psychiatrists press for sweeping expansion of telehealth as part of pandemic responses', 31 March 2020 <https://croakey.org/psychiatrists-press-for-sweeping-expansion-of-telehealth-as-part-of-pandemic-responses/>.

[200] Department of Health and Human Services, 'COVID-19 Telehealth consulting and conferencing: Privacy and security Telehealth usage rules' <https://bit.ly/3bNeBrG> [accessed 10 August 2020].

face-to face contacts was 44.9% below SPLY[201]; ambulatory service contacts by telephone was 40.6% above SPLY; and ambulatory contacts by videoconference was 3,100% above SPLY. This pattern has been mirrored in GP and private psychiatry practice.

182. **Anecdotal feedback from some patients, families and clinicians is positive[202] but there are many unanswered questions at this point, not the least of which is "Who is missing out and why**?" The technology has allowed many clinicians with health risks to work from home and has ensured that patients have been able to continue to access care while maintaining physical distancing. But it is unclear whether patients are missing out on care because they lack access to telephones and smart phones, or whether they cannot afford data access. Insofar as the demand data is concerned, it is possible that the pandemic has had an impact on reducing alcohol and other drug use, either through supply or affordability constraints, and this has led to fewer behavioural crises. It is also possible that the pandemic has led to consumers avoiding contact with health services due to fears they could be harmed; or that the reduction in face-to-face service is putting off new clients from accessing services and reducing the amount of contact by existing clients. The data needed to answer these questions is still being collated and a deeper understanding of current demand awaits further exploration.

183. **Although the introduction of telehealth MBS items is temporary, the flexibility it has brought to practice in the private setting is such that it is hard to imagine patients wanting to return to an arrangement whereby mental healthcare can only be obtained through a face-to-face contact**. Furthermore, given the fact that funding considerations such as the MBS do not shape practice in

[201] Same period last year

[202] Personal Communication from discussions with Clinical and Operational Directors of Victoria's mental health services in May 2020.

the public sector, it is even harder to imagine telehealth will not continue to be a component of service delivery well beyond the end of the pandemic. What is yet to be determined is the degree to which this modality suits all patients; who misses out and why; and how clinicians will go about working out the right mix of face-to-face and telehealth for individual clients in future.

9. OPPORTUNITIES FOR DIGITAL TECHNOLOGIES AND CHALLENGES TO IMPLEMENTATION

184. The opportunities for mental health as a result of the adoption of digital technology are substantial. It strikes me that the impact of telehealth on clinical mental health practice will be like that of the smartphone on our social and cultural life. The possibilities and the risks of the smartphone were not immediately evident when the first model arrived on the market in 1992 203. The Apple iPhone, the first device to be accessible to a mass market followed in 2007. Improvements in technology and software development since have made the smartphone an indispensable part of life, with social consequences that were difficult to foresee as recently as a decade ago. I suspect the same will be true of telehealth. At this point in time, the immediate benefits of digital approaches to routine mental health care evident to me include efficiency, as clinicians do not have to spend time moving between client settings and can see more patients in the time available to them; effectiveness, as the technologies provide for greater flexibility and the possibility of greater responsiveness to the needs of consumers and families; access, as consumers and carers are able to source evidence-based treatments that are either on-line or therapeutically guided. The interest of consumers and carers in the technology and their participation in the development of treatment options will no doubt improve the effectiveness of interventions and their adoption by service users. I have little doubt that in time, digital technologies will create a new paradigm for mental health

[203] It was called, interestingly for me alone I suspect, the IBM Simon.

services that will transform the ways in which treatment is delivered, information is shared and recorded, and the workforce is recruited, trained and developed.

185. In their paper titled "The WPA-Lancet Psychiatry Commission on the Future of Psychiatry", Bhugra et al wrote; "Digital technology might offer psychiatry the potential for radical change in terms of service delivery and the development of new treatments." (2017, pg 775)204 The overnight emergence of telehealth as a major tool in mental health services since the emergence of COVID-19 in 2020 has been a substantial validation of this view. In opening the door to implementing digital technologies into routine practice, the pandemic has raised questions about whether further opportunities and challenges lie ahead.

186. There is an extensive literature on the applications of digital technologies in mental health. Internet- and mobile-based interventions (IMI) have emerged rapidly over the past decade and have been viewed as a possible solution to the gap between the prevalence of mental illness in the community and the number of people in treatment. Interventions can be categorised according to three factors. They can vary according to: [1] Human support, ranging from unguided to therapeutically guided interventions that provide feedback on the progress, motivational messages and monitoring safety issues; [2] Evidence-based theoretical background, with most interventions being based on cognitive behaviour therapy approaches or iCBT; and [3] Mode of delivery, including online webpages or mobile apps that can integrate chat, video, audio, email or SMS functions. There is further research underway, looking at other modes of delivery. Thus, gaming can be a benefit, both as a treatment methodology (such as practicing self-soothing using heart rate monitors) or to connect and break down loneliness (such as online multiplayer games). There are emerging opportunities in big data and artificial technology, for example as diagnostic tools or to help identify tailored treatment approaches based on a

[204] Bhugra et al. 'The WPA-Lancet Psychiatry Commission on the Future of Psychiatry', *The Lancet Psychiatry Commission* 4(10) (2017), 775-818.

combination of inputs such as physiological (genetic, blood test, scans, etc.), historical (case records), self-report information and research data.

187. IMI as a form of treatment for several mental disorders has been shown to be potentially as effective as face-to-face psychotherapy when provided as therapeutically guided interventions. The evidence base for treating diagnosed outpatients with depression, anxiety disorders, psychotic disorders or across diagnoses is promising. Studies with inpatient samples are largely lacking.

188. In my experience, there have been several key obstacles to implementation of digital technologies into routine mental health practice.

189. The first has involved **access to the devices, data plans and bandwidth** required for providers and patients to take advantage of the full capability of these technologies. This has been an issue for clinicians in some but not all services, where investment in appropriate bandwidth and mobile technologies has been slow. Many organisations have promoted a "bring your own device" policy but have lacked an infrastructure to allow for all staff, admitted patients, and visiting outpatients and family members to connect easily to wireless systems. This is changing rapidly and the impact of COVID-19 has further accelerated that process. Some consumers and carers living in the community remain disadvantaged with respect to access to data plans and devices and are unable to take advantage of the new technologies. The Victorian government announced a funding package on 12 April 2020 to supply phones and extra data to vulnerable and high-risk clients of public mental health services, so they could stay engaged with treatment and services[205]. The impact of this package is difficult to quantify, though data indicates that as of 12 June 2020, the latest 7-day average of the number of ambulatory

[205] The Hon Daniel Andrews, Premier of Victoria, Media Release: ' Surge Funding Helping Our Mental Health System During Crisis' <https://www.premier.vic.gov.au/surge-funding-helping-our-mental-health-system-during-crisis/>.

service hours provided by Victoria's mental health services was 1.7% higher than the same period last year (**SPLY**). The number of ambulatory service contacts was 7.6% higher than SPLY. This occurred despite a 33.8% decrease in the number of direct face-to-face ambulatory service contacts, but in the context of a 30% increase in contacts by telephone and a 3,107% increase in contacts by video. The number of telephone contacts was about ten times greater than the number of video contacts[206]. At the very least, the pandemic had not slowed the provision of community services as a result of the reduction of face-to-face contact. This could indicate that programs to enhance client access to data and devices were successful or that problems with access did not exist in the first place. More evaluation is required.

190. The second obstacle to implementation has involved the **absence of research to provide a model for how to implement IMI as part of inpatient and outpatient routine care**. There is ample opportunity now to remedy that deficit in Victoria. Funding by the Victorian government of Orygen Youth Health's new eOrygen Moderated Online Social Therapy (**MOST**) platform will provide access to online therapy and peer support for young people. MOST prototypes have already been shown to be safe, effective and engaging for young people at all stages of treatment and across diagnostic and severity spectrums[207][208]. This initiative now offers an opportunity to determine whether such a platform can have an impact on the mental health of the youth population, and if so, which elements are more effective than others. There are other opportunities for research to be pursued given the widespread uptake of telehealth into adult services in Victoria. It is already known

[206] Victoria Agency for Health Information 'Impact of COVID-19 on mental health and alcohol and other drug treatment services in Victoria', 2020.

[207] Thompson A, Gleeson J and Alvarez-Jimenez M 'Should we be using digital technologies in the treatment of psychotic disorders?' *Australia New Zealand Journal of Psychiatry* 52 (3) (2018), 225-226.

[208] Alvarez-Jimenez M et al. 'Online, social media and mobile technologies for psychosis treatment: a systematic review on novel user-led interventions' *Schizophrenia Research* 156(1) (2014), 96-106.

that digital mental health aftercare as stand-alone or as blended care has proven to be promising in terms of reducing symptoms and recurrence rates[209]. There is, however, no data with respect to the use of digital mental health in inpatient settings. I am aware through personal communications that telehealth is being widely used in Victorian inpatient mental health units during the COVID-19 pandemic, as many services have sought to reduce their inpatient staff to the risk of infection by rostering their staff to work from home part of each week. Again, this is an opportunity that is live and could inform practice in future.

a) The third obstacle relates to a concern that **managing risk may be impaired** by the lack of face-to-face contact. Recent meta-analyses show that the use of guided and unguided IMI for depression symptoms led to fewer clinically significant deteriorations than in a waitlist or treatment as usual groups, thus reducing risk[210]. There is clearly more work that needs to be done in this area, though again vast experience is now being gained through the COVID-19 pandemic and the rapid uptake of telehealth in this context. There is little evidence of higher rates of intentional self-harm or suicide from registered clients of Victorian mental health services in whom signs of clinical deterioration are being missed.

b) There are other barriers that need to be considered, explored and understood and these include the lack of customizability; concerns about decreased therapeutic alliance; the possibility of technical problems; and low acceptance of digital interventions.

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[209] Dulsen P et al. 'Digital interventions in adult mental healthcare settings: recent evidence and future directions' *Current Opinion Psychiatry,* 33 (4) (2020), 422–431.

[210] Karyotaki E, Kemmeren L, Riper H, et al. 'Is self-guided internet-based and cognitive behavioural therapy (iCBT) harmful? An individual participant data meta-analysis', *Psychological Medicine*, 48 (15) (2018), 2456–2466.

191. There is a recognition within DHHS that the response to COVID-19 has rapidly normalised client interaction through digital platforms and set up a digital revolution of sorts. It is expected that these practice changes will continue to evolve following the pandemic, and that the delivery of mental healthcare through digital platforms will enable new kinds of services and models of care to emerge, augmenting and potentially supplanting existing ones. These new practices will require new guidelines, and possibly enable new roles and responsibilities. In many ways, the digital revolution in mental healthcare should improve access to mental healthcare and to the kinds of evidence-based treatments that have been previously difficult to provide at scale. There is an urgent need to evaluate its impact in the short term. Information should be gathered on changes that have been made across the sector during the pandemic, and their impact, so that the lessons learned are not lost during the transition to recovery. To this end, DHHS's Centre for Evaluation and Research Evidence will undertake a mental health rapid review to focus on two key service delivery changes: teleconferenced Mental Health Tribunal hearings, and the use of telehealth across mental health services. The review will be undertaken with consumers and carers of public mental health services, clinicians, Mental Health Tribunal and legal representatives and other key stakeholders including the Victorian Mental Illness Awareness Council and Tandem. Steps will be taken to ensure that the evaluation is data driven and reflects the experiences of the mental health workforce, consumers and carers before new initiatives are proposed.

192. It would be useful, in my view, if DHHS were to establish infrastructure requirements for uptake of telehealth and other digital technologies and audit existing hospital and community health services to determine their capacity to adopt this approach at scale. This could help guide the development of a masterplan for IT infrastructure and guide continued investment. Consideration should also be given to working with community partners, including GPs, community health and non-government organisations to explore local options to facilitate client access to the benefits of digital technologies. This can be achieved through the development of an electronic medical record architecture that allows for the sharing of clinical information across hospital and primary platforms. The My Health Record platform

remains cumbersome to use and its uptake has been slow. It remains nevertheless the most promising foundation of an approach to record sharing in Australia and should continue to evolve. Other interventions to improve access to telehealth should be explored and evaluated, including programs that improve the affordability of data plans and devices and provide telehealth hubs in local community settings, including community health services, as a gateway to primary and specialist healthcare.

10. COULD THESE CHANGES EMERGE INTO LONGER TERM OPPORTUNITIES FOR NEW APPROACHES TO SERVICE DELIVERY, FOR THE BENEFIT OF MENTAL HEALTH CONSUMERS AND CARERS?

193. **The simple answer to this question is yes**. The first lesson to be learnt from the pandemic is that local health service governance with strong executive support was able to facilitate the changes required to transform not only emergency and critical care, but also the mental health system response. It must be said that specific guidelines from DHHS intended to steer this transformation tended to follow days or weeks after services had already implemented changes to service delivery in inpatient and community settings. The level of clinical and operational expertise available in our services provided the capacity necessary to shift mental health service delivery onto digital platforms in Victoria, even in the absence of a blueprint for direction. This ability of health services to respond to an urgent need for change should be taken into consideration as the Royal Commission considers how mental health services should be governed in future. I worry that an approach to mental health service delivery that isolates it once more will deprive it of the lifting power that can be harnessed when health services are fully engaged in the mission at hand. I believe that solutions to the adaptive leadership challenges experienced by mental health services require the engagement of health service executives and should be more easily within reach. Health services have shown themselves to have enormous capacity in meeting the substantial challenge of COVID-19 and this

should fill us with optimism. The challenge for the implementation of mental health reform will be to ensure that senior health service decision makers are involved more directly and are held more accountable than may have been the case to date.

194. Australia's public health system more broadly had responded to the COVID-19 pandemic with great success at the time of writing, Victoria's second wave notwithstanding. This was in no small part due to the role played by our Commonwealth, State and Territory governments who were able to join in a National Cabinet process and deliver a level of collaboration not seen for many years. So successful had the format been during the pandemic that Prime Minister Morrison announced on 29 May 2020 that it was to replace the Council of Australian Governments (**COAG**) permanently[211]. The national cabinet includes among its seven reform committees one on health. One of its early achievements was to develop the "National Mental Health and Wellbeing Pandemic Plan"[212] This was a welcome development that would be greatly enhanced by further investment in programs that touch upon the social determinants of mental health. In my opinion, the priorities in this domain are very much reflected in the findings of Morgan et al, that poverty, social isolation and loneliness, unemployment, poor physical health and housing are among the top barriers to recovery experienced by people with severe mental illness such as psychosis[213]. Income support that provides a liveable wage; access to affordable housing; social connection and engagement with

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[211] Paul Karp, The Guardian, '"Coag is no more": national cabinet here to stay with focus on post-Covid job creation', 29 May 2020 <https://www.theguardian.com/australia-news/2020/may/29/coag-is-no-more-national-cabinet-here-to-stay-with-focus-on-post-covid-job-creation>.

[212] National Mental Health Commission, 'National Mental Health and Wellbeing Pandemic Response Plan' <https://www.mentalhealthcommission.gov.au/Mental-Health-and-Wellbeing-Pandemic-Response-Plan#:~:text=The%20total%20response%20called%20for,a%20result%20of%20the%20pandemic> [accessed 10 August 2020].

[213] Morgan VA et al. 'Responding to challenges for people with psychotic illness: updated evidence from the Survey of High Impact Psychosis', *Australia New Zealand Journal of Psychiatry* 51 (2) (2017),124-40.

meaningful leisure, training, education and/or employment activities are all critical to delivering better outcomes for mental health consumers and their families.

195. Despite its success, there remains room for improvement, especially with respect to health system readiness. It is anticipated that the pandemic will result in increased demand for mental health services, but clear roles and responsibilities for Commonwealth and State governments to deal with this demand have not been adequately established. A national surveillance strategy for the collection, analysis and real time reporting of data at a national level is emerging, as is a capacity for modelling future demand. These are all welcome developments that will enhance the capacity of the system to plan to meet mental health demand, even more so if data is available at a regional and local level to facilitate place-based initiatives and local partnerships.

196. The workforce in many health services has had a high level of engagement with the tasks undertaken by health services to prepare for the pandemic. This has led to a level of flexibility, cooperation and goodwill that was unprecedented. Ongoing secondments, redeployments, job redesign, relocations and extended hours were all made possible in the context of the pandemic, processes that in normal circumstances could take months if not longer to negotiate. It remains to be seen whether this level of flexibility will be retained once the response to the pandemic has concluded.

197. **Within the general health sector, service efficiency was enhanced by connecting private and public health services** and directing elective procedures into the private sector. It bears repeating that public mental health services were never required to refuse admission of patients during the first wave of the pandemic to June 2020. The demand simply wasn't there. But after our eventual recovery, it bears exploring whether such linkages with the private sector could be used to hlep manage demand for the treatment of uninsured patients. Clearly, there are major threshold questions that would need consideration, including whether private facilities can manage compulsory patients and moderate to high behavioural risk,

and whether they can deliver the same services for a similar price. There are already existing public-private partnerships involving North-Western Mental Health Service and Monash Health, but these do not treat compulsory patients or patients at moderate to high risk. The private beds initiative that will be undertaken by MHRV in collaboration with the public and private sectors will attempt a different approach and could well shed light on the answers to some of these questions.

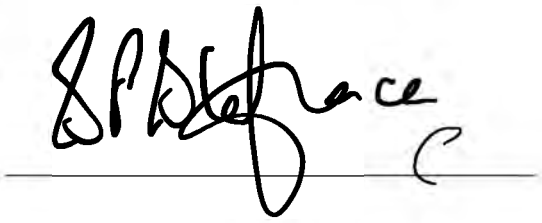
198. **The Productivity Commission has floated the idea of pooling funding into regional authorities in its draft report on mental health**[214]. The pandemic does raise the prospect that such collaboration could be possible, useful and effective in driving reform. A challenge moving forward will be to integrate regional planning and system management across acute specialist and primary care sectors. The pandemic showed how powerful the States' hierarchical relationship with hospitals is. State governments were able to direct hospitals to act in the public interest even when this involved closing elective surgical operating lists and reducing discretionary activity. In contrast, the Commonwealth only has a market relationship with providers, and therefore has a vested interest in working more closely with the States, possibly through the PHNs, to create regional approaches to primary and hospital care. The possibilities are substantial if collaborative practice through service partnerships can be underpinned by funding agreements, shared data and integrated care pathways, especially for chronically ill consumers with complex needs.

199. **Finally, telehealth must remain a key technology for use within mental health services**. Access should be improved. The telehealth item numbers introduced at the beginning of the pandemic were simply a translation of existing GP and specialist item numbers. They were introduced without much thought and did not enforce desirable forms of practice. This should change. Publicly funded mental

[214] Productivity Commission, 'Mental Health Draft Report: Overview and Recommendations' <https://www.pc.gov.au/inquiries/completed/mental-health/draft/mental-health-draft-overview.pdf>.

health services should keep telehealth. It is associated with reductions in no shows and anecdotal reports indicate many patients approve of the arrangements if they have access to devices and data. The mental health system must reflect on what it has learned from the introduction of telehealth and evaluate how it can best be used, for what problems, and in what proportion to direct contact with consumers. There is also an opportunity to reflect on what kind of health system needs to emerge from the pandemic and what "building back better" could look like. Consumers should be able to choose their preferred method of contact with the mental healthcare system. Face-to-face contact remains critical in the assessment and high-risk phases of care and should never be abandoned. But neither should it remain the only method of engagement for consumers and carers. Access to evidence-based treatments should be enhanced. The development of nurse and allied health models of care should be explored. Investment in infrastructure, training, evaluation and research should be a priority and expansion of the technology should be accompanied by programs to address the barriers of the digital divide.

Royal Commission into
Victoria's Mental Health System

sign here ▶ 

print name SIMON PETER STAFRACE

date 14 August 2020

ATTACHMENT SPS-1

This is the attachment marked 'SPS-1' referred to in the witness statement of Associate Professor Simon Peter Stafrace dated 14 August 2020.

11. CURRICULUM VITAE

11.1 NAME & POSITION

(a) Associate Professor Simon Stafrace

(i) Chief Adviser, Mental Health Reform Victoria, Department of Health and Human Services, Victorian Government

(ii) Clinical Adjunct Associate Professor, Central Clinical School, Monash University, Victoria, Australia

11.2 **CONTACT DETAILS**: Address/ Mental Health Reform Victoria, 50 Lonsdale Street, Melbourne, Victoria, 3000

11.3 CURRENT EMPLOYMENT

(a) Chief Adviser, Mental Health Reform Victoria| Department of Health and Human Services, Victorian Government|2020- Present

As Chief Adviser, I report to the CEO of Mental Health Reform Victoria (**MHRV**), an administrative office within the Department of Health and Human Services in the Victorian Government, established in February 2020 for two years. I provide high-level, authoritative, expert mental health advice on implementation of the recommendations of the Royal Commission into Victoria's Mental Health System (**RCVMHS**). This

includes advice to the Minister, the CEO of Mental Health Reform Victoria and the broader team to ensure the implementation work is true to the original vision and intent of the Royal Commission. Following onset of the COVID–19 pandemic, I am also an executive member of the COVID-19 Mental Health Response and Recovery Team (**MHRRT**), a collaboration of MHRV and the Mental Health and Drugs Branch within DHHS. Its purpose is to support the Victorian Mental Health System response to the pandemic, and ensure efforts are aligned and integrated effectively with the Health and Wellbeing COVID-19 Project Management Office (**PMO**), the State Health Emergency Management Team (**SHEMT**) and the recommendations of the RCVMHS.

(b) Alfred Health / Program Director of Mental and Addiction Health| 2006 – Present (On Secondment to the Department of Health and Human Services, Victorian Government)

I lead a public area mental health service in inner southeast metropolitan Melbourne, with a catchment population of about 400,000. We provide mental health and addiction services in hospitals, community residential units and clinics across 12 sites, as well as an academic/research centre managed in partnership with Monash University. In 2019-20, our budgeted revenue was over $A80 million per annum and we employed over 750 full time equivalent staff.

(c) Monash University / Adjunct Clinical Associate Professor| 2011 – Present

I am an active contributor to undergraduate and postgraduate psychiatry teaching at Alfred Health. I am responsible for ensuring the availability of clinical resources for undergraduate teaching and clinical research and am accountable for postgraduate medical training. I lead a service evaluation stream of research and our team has published articles in peer-reviewed

mental health journals and other mediums, undertaken service consultations and delivered oral presentations at national and international conferences and clinical service forums.

(d) Clinical and Leadership Consultancy Services In Specialist and primary Mental Health | 2005- *Present*

Clients have included SA Health (including the First Oakden Review[215]), Tasmanian Health Service, Eastern Melbourne PHN, Eastern Health, Ballarat Health, and Peninsula Health.

11.4 PAST EMPLOYMENT

- Medical Panels of Victoria | Psychiatrist Member| 2012 - 2016
- Alfred Health (Caulfield Hospital) | Director, Aged Psychiatry Service| 2000 - 2006
- Psychiatrist in Private Practice | Incl. Admitting Rights to Delmont Hospital, Melbourne Clinic and Northpark Hospital| 1996-2006
- Monash University | Senior Lecturer| 2004-05
- St George's Hospital (now St Vincent's Health) | Psychiatrist, Aged Psychiatry Service| 1998-2000
- Bundoora Extended Care Centre (now Melbourne Health) | Psychiatrist and Acting Director, Aged Psychiatry Service| 1996-1998

[215] http://bit.ly/2rNdYK2

- Bundoora Extended Care Centre (now Melbourne Health) | Registrar- Advanced Training in Aged Psychiatry and Research Associate (Centre for Gerontology) | 1996-1998

- Northern Metropolitan Psychiatry Training Program, Victoria| Registrar- Basic Training| 1991-1995

    - Adult Psychiatry- Crisis Assessment and Treatment, Plenty Hospital, North-Eastern Melbourne Psychiatric Service (**NEMPS**)

    - Aged Psychiatry- Assessment Team (**APAT**), Wildara Community Clinic, NEMPS

    - Adult Psychiatry- Mood and Eating Disorders Unit, Larundel Hospital, NEMPS

    - Aged Psychiatry- IPU and Community- Peter James Hospital (now Eastern Health)

    - Liaison Psychiatry- St Vincent's Hospital (Melbourne)

    - Adult Psychiatry- Inpatient Rehabilitation, Larundel Hospital, NEMPS

    - Child and Adolescent Psychiatry- SE Child and Family Centre (Melbourne) (now Alfred Health)

    - Adult Psychiatry- IPU and Outpatients, Maroondah Hospital (now Eastern Health)

- Box Hill Hospital (now Eastern Health) | Intern and HMO| 1989-1991

11.5 ACADEMIC QUALIFICATIONS and KEY CONTINUING PROFESSIONAL DEVELOPMENT

- La Trobe University | Master of Health Administration (MHA)| 2005
- Monash University | Graduate Diploma, Health Services Management| 2004
- Royal Australian and New Zealand College of Psychiatrists| Accredited Membership of the Faculty of Psychiatry of Old Age |1999
- Monash University | Master of Psychological Medicine (MPM)|1998
- University of Melbourne | Graduate Diploma, Mental Health Sciences (Clinical Hypnosis) | 1998
- Royal Australian and New Zealand College of Psychiatrists| Fellowship (FRANZCP)| 1996
- University of Melbourne | Bachelor of Medicine, Bachelor of Surgery (MB BS)| 1988

11.6 KEY CONTINUING PROFESSIONAL DEVELOPMENT

- Company Directors' Course| Australian Institute of Company Directors| 2020
- London School of Hygiene and Tropical Medicine| Executive Programme Global Health Leadership| 2018
- Leadership Victoria | Williamson Community Leadership Program| 2016

- Fellow, Australian Institute of Management| 2002

- Primary Certificate in Rational-Emotive Behaviour Therapy, Australian Institute for Rational-Emotive Therapy| 1999.

- AMA 4 Guides Impairment Assessment Training Program, Core and Psychiatry (Stream 2)| 2001 and 2011.

- Australian Society of Hypnosis | Diploma, Clinical Hypnosis| 1993

11.7 Honours and Awards

- Margaret Tobin Award| RANZCP| 2016

- Travelling Fellowship for Old Age Psychiatry, Faculty of Psychiatry of Old Age| RANZCP and Lundbeck Institute| 1999

- Maddison Medallion| RANZCP| 1997

- Travelling Scholar| RANZCP WA Branch| 2019

- Holt Australia Day Award| Anthony Byrne MP| 2019

11.8 Boards and Committees- Current

- RANZCP| Co-chair Community Collaboration Committee| 2018-Present

- Metropolitan Partnerships-Inner South-East | Community Member| 2017-Present

11.9 Boards and Committees- Past

- Mental Health Victoria| Board Director| 2018- 2020
- Tandem Victoria | Board Director| 2016-2020
- RANZCP | Deputy Chair, Education Committee| 2012-15
- Sacred Heart Mission, Journey to Social Inclusion Project | Member Steering Group| 2009-12
- RANZCP, Faculty of Psychiatry of Old Age| Director of Advanced Training (Vic)| 2005-06
- RANZCP, Faculty of Psychiatry of Old Age| Branch Sec (Vic)| 1999-2006

12. Publications

1. Lee SJ, Thomas P, Freidin J, Newnham H, Lowthian J, Smith C, Borghmans F, Gocentas R, DeSilva D, **Stafrace S**. Homeless status documentation at a metropolitan hospital emergency department. Emergency Medicine Australasia. 2019 Aug;31(4):639-645

2. Lee SJ, Thomas P, Freidin J, Newnham H, Lowthian J, Smith C, Borghmans F, Gocentas R, DeSilva D, **Stafrace S**. Injury, illness, mental illness and lost housing: The many reasons why people who are homeless attend hospital emergency departments. Parity (2018). 201, 31:40-2

3. Lee SJ, de Castella A, **Stafrace S**, Keppich-Arnold S, Kulkarni J. Retrospective audit of people treated with long-acting antipsychotic injectable medications: usage patterns and outcomes. Schizophrenia Research 2018; 197:572-573

4. Filia SL, Gurvitch CT, Horvat A, Shelton CL, Katona LJ, Baker AL, **Stafrace S**, Keppich-Arnold S, Kulkarni J. Inpatient views and experiences before and after implementing a totally smoke free policy in the acute psychiatry hospital setting. Int J Mental Health Nursing 2015 Aug; 24(4): 35—9.

5. Lee SJ, Thomas P, Doulis C, Bowles D, Henderson K, Keppich-Arnold S, Perez E, **Stafrace** S. Outcomes achieved by and police and clinician perspectives on a joint police officer and mental health clinician mobile response unit. Int J Ment Health Nurs. 2015 Dec;24(6):538-46

6. Lee S, Collister L, **Stafrace S**, Crowther E, Kroschel J and Kulkarni J. Promoting recovery via an integrated model of care to deliver a bed-based, mental health

prevention and recovery centre. Australasian Psych (2014); 1-8

7. Kulkarni J, Gavrilidis E, Lee S, Van Rheenen TE, Grigg J, Hayes E, Lee A, Ong R, Seeary A, Andersen S, Worsley R, Keppich-Arnold S, **Stafrace S**. Establishing female-only areas in psychiatry wards to improve safety and quality of care for women. Australasian Psychiatry. 2014 Dec; 22(6): 551-56

8. Lee S, Hollander Y, Scarff L, Dube R, Keppich-Arnold S and **Stafrace S**. Demonstrating the impact and model of care of a Statewide psychiatric intensive care service. Australasian Psych (2013)21; 466-71.

9. Konstantatos AH, Angliss M, Costello V, Cleland H, **Stafrace S.** Predicting the effectiveness of virtual reality relaxation on pain and anxiety when added to PCA morphine in patients having burns dressings changes. Burns (2009), 35(4), 491-499.

10. **Stafrace S** and Lilly A. Turnaround in an aged persons' mental health service in crisis: a case study of organisational renewal. - Australian Health Review (2008), 32(3) 577 – 582.

11. **Stafrace S.** Self-Esteem, Hypnosis and Ego Enhancement. Australian Journal of Clinical and Experimental Hypnosis 2004, 32; 1-35

12. O'Connor D, Horgan L, Cheung A, Fisher D, George K, **Stafrace S**. An audit of physical restraint and seclusion in five psychogeriatric admission wards in Victoria, Australia. Int J Geriatr Psychiatry. 2004 Aug;19(8):797-9.

13. Ames, D., and Stafrace, S. (1999). Psychiatry of Old Age: A Symposium Edited by David Ames and Simon Stafrace: Has the psychiatry of Old Age Come of Age? *Australian and New Zealand Journal of Psychiatry, 33*(6), 782–784.

14. **Stafrace S.** Hypnosis in the treatment of panic disorder with agoraphobia. Australian Journal of Clinical and Experimental Hypnosis 1994, 22, 73-86.

15. Lydall-Smith S, **Stafrace S**, Ecclestone L. NEMPS Relocation Study. Volume 1: Summary Report. Occasional Paper #3, May 1998. Centre for Applied Gerontology, Bundoora Extended Care Centre, Bundoora.

16. Lydall-Smith S, **Stafrace S**, Ecclestone L. NEMPS Relocation Study. Volume 2: Technical Supplement. Occasional Paper #3, May 1998. Centre for Applied Gerontology, Bundoora Extended Care Centre, Bundoora.