Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF NICOLE BARTHOLOMEUSZ

I, Nicole Bartholomeusz, Chief Executive, of cohealth, of 365 Hoddle Street, Collingwood in the State of Victoria, say as follows:

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

2 I am giving evidence to the Royal Commission in my professional capacity as the Chief Executive of cohealth.

Background

3 I am currently the Chief Executive of cohealth and have been since September 2019.

4 cohealth is a not-for-profit community health organisation that strives to improve the health and wellbeing for all and lead the way in reducing health inequity in partnership with people and the communities in which they live. cohealth delivers a wide range of low cost, high-quality, accessible health care and support services including medical, dental, allied health, mental health, aged care and counselling, and many specialist health services across Melbourne's CBD, northern and western suburbs.

5 I am also currently a National Council Member of the Australian Healthcare & Hospitals Association.

6 Prior to being appointed Chief Executive, I held the following roles at cohealth:

a) Acting Chief Executive from July to September 2019;

b) Deputy Chief Executive from November 2016 to September 2019; and

c) Executive Director Operations & Deputy CEO from May 2014 to November 2016.

7 I have previously held the following roles:

a) Western Health: Non Executive Director (4 months), Chair – Population Health Advisory Committee and Member – Cultural Diversity and Community Advisory Board Committee;

b) Western Region Health Centre: Interim Chief Executive (December 2013 to May 2014), Deputy Chief Executive Officer (September 2012 to January 2014), Company Secretary (2010 – 2014) and General Manager Health Outcomes (June 2006 to September 2012);

c) Non-Executive Director, Macedon Ranges North Western Metropolitan Medicare Local from 2011-2014;

d) Principal Consultant, Nicole Bartholomeusz Consulting from April 2005 to June 2006;

e) Dental Health Services Victoria: State Manager School Dental Service (2003-2005), Interim Director Community Dental Services (November 2002 to March 2003), Regional Manager (2000-2002) and Regional Co-ordinator of the Eastern Region (1997-2000.)

8 I also have the following qualifications:

a) Master of Business Administration, La Trobe University, 2005:

b) Graduate Diploma Community Health, La Trobe University, 1996; and

c) Diploma of Applied Science (Dental Therapy). School of Dental Therapy,1991.

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

PANEL QUESTIONS

Question 1: In thinking about an ideal future community mental health system in Victoria, which services components or supports are critical in effectively supporting:

People experiencing mild mental illness?

10 In order to effectively support people experiencing mild mental illness, an early prevention and intervention approach is key.

11 This includes community capacity building programs that keep people connected and build local relationships and networks of care and support. Many people are isolated, unable to find meaningful work or education and lack connections to people and community activities. Providing opportunities for meaningful connection enables "hope/recovery". These are often simple initiatives, but it is critical they are local and developed by the people who are impacted with access to good psycho-education.

12 Appropriate early support for families is a critical factor in building resilience and determining children and young people's ability to manage in later life. Health promotion for younger ages should involve families in developing skills to manage child rearing

and opportunities for non-judgemental connections with other families and supporters to build networks around families. Such examples could include non-costly activities and enable participation in recreation, sport, music at local levels, that are built and developed by the families in local communities. Examples in local communities can include shared child-care/play group arrangements, community cooking or walking, where parents are engaged in positive ways with their children. Importantly, community education is also key.

13 There must be an early identification of issues with accessible choices of non-medical solutions. These can include peer support, family support, counselling, therapy, massage, mediation support, exercise options, on-line and face to face services. Options need to be accessible for the person seeking support – affordable, in the location and at a time that suits them and culturally safe. They also need to be delivered in a way that meets their preference, whether that's in person, online, over the phone or in group settings.

14 The common drivers for poor mental health are racism, discrimination, family violence, housing, stress, poverty, alcohol and other drug (**AOD**) related issues. There needs to be effective interventions in relation to these social issues to prevent the onset or escalation of mental illness. The principle is that we need to ensure that we have the societal structures that support good mental health. This will lay the foundation of preventing mental ill health. Poverty, racism and discrimination, family violence, housing insecurity and homelessness are all causes of mental ill health. If we address these – ensuring adequate secure affordable housing, reducing poverty, ensuring services that support people who have experienced trauma are well resourced, and working towards an inclusive society – the incidence of mental ill health will be reduced.

People with moderate mental illness?

15 In relation to people with moderate mental illness, the focus should be on appropriate early identification and interventions to prevent the mental illness from becoming acute and chronic. This includes support that addresses the drivers of poor mental health discussed at paragraph 14.

16 People with moderate mental illness should have choice of different modalities that are easily understood and accessible. Psychology is mainly funded through the Medicare Benefits Schedule and is for a limited number of sessions, which may not be sufficient to provide the therapeutic support needed. People should have a choice of a range of counselling and support options, and the number of sessions they need to provide them with support.

17 Counselling can be hard to access: in many areas there is a shortage of practitioners, many therapists charge a co-payment, and the cost is then prohibitive for many people, particularly those we work with. Many counsellors use Cognitive Behavioural Therapy, which is not always the best modality for people who require longer term supportive counselling.

18 Access to affordable exercise, massage, meditation and other self-identified ways of managing stress and anxiety are important, and people should have access to either face to face or online options that best suit their preferences.

19 If a person is seeking support for other issues, such as alcohol and other drug use, that workforce should consider potential mental health implications. There should be a more integrated response, and the broader health care workforce should be up-skilled to recognise mental illness.

20 By way of example, alcohol and other drug issues and mental health often occur together. However, the service systems are separate and the differentiation is not helpful for many people. Whilst different acute treatments are appropriate the more critical community supports should see mental health and AOD workers all trained across both areas as mental health is often the driver of AOD issues. An ideal future workforce is one that is trained in both areas.

21 The Housing and Support Program from the early 2000's, now rebranded Housing First, has the central principle that housing is stable and linked to support. These programs provide evidence that with housing security people are able to have hope and begin their journey of recovery. Other supports are brought in as required. More serious mental health issues can be identified early, and appropriate support provided.

22 Our consumer choice pilot project (winner of 2016 Victorian Public Healthcare Award for mental health) reallocated some funding to enable consumers to purchase time-limited, mainstream services on behalf of the client. The purchased service is directly related to the client's recovery goals and is a component of their support package that would otherwise be unavailable. This allowed consumers to undertake their chosen activity and enabled many people to find creative ways of working, earn money and slowly be able to re-join the community as they built confidence and skills.

People experiencing severe or chronic mental illness?

23 There needs to be a broader continuum of treatment-based services available for people experiencing severe or chronic mental illness, ranging from community-based services to psychiatric intervention.

24 People experiencing severe or chronic mental illness can be well maintained within the community, with the appropriate support mechanisms and community-based services such as counselling, the collaborative recovery model and day to day living support functions. These supports are important to ensure that a person with chronic mental illness can remain in the community. While acute responses will be required for acute episodes, there must also be a model for recovery so that a person experiencing severe or chronic mental illness can self-manage their mental illness in the community.

Families and carers?

25 Support and services for families and carers are critical. There is a significant impact on families and carers who are supporting people with mental illnesses. Families and carers require respite, support and education. Families and carers often shoulder a large responsibility for the care of their loved one. While this role is taken up willingly by family members and other carers, they tell us about the burden this places on them, particularly when the care is needed for a lengthy period of time, or the needs are complex.

26 Improved services to provide support to people with mental illness would help relieve this burden. Too often we hear that the person with mental illness is unable to receive treatment and care from the service system, so family and other carers pick up this role. At the same time, carers benefit from support that is tailored to their needs – peer support from other carers, information about their loved one's condition and treatment, and opportunities for counselling, financial and practical support. Often, a carer's health and well-being is secondary to that of the person that they are caring for. A future system must assist the carer to access timely support – prevention, earlier intervention, education, peer supports and treatment services, as required. Anxiety, grief, ill-health and poverty are often associated with the caring role and people have very little access to the support they or their loved one require.

Question 2: At a system level, what strategies can be employed to achieve the right balance between early access to mental health assessment and treatment, and managing the demand for mental health services?

27 In order to keep people well, psychosocial support must be available along with support for early intervention, recovery and pathways for an acute response, if required. At a system level, investment is needed in the services that relate to underlying drivers of poor mental health, such as housing, alcohol and drug issues and family violence.

28 Before intervention, there needs to be key health promoting activities that begin at an early age. This includes school education programs, resilience building, focus on understanding depression, anxiety and low prevalence conditions, reducing stigma, the

impact of poverty and unemployment. If these can be understood and recognised by young people then people have a chance to get help when needed. All of these need to be undertaken in a community capacity building approach.

29 If we can address the deep underlying drivers of poor mental health, in the long run we will significantly prevent mental illness. This is preferable to only treating a person once a mental illness occurs and then combining treatment and rehabilitation. If we can actually invest in those social determinants for mental health, we will significantly reduce poor mental health in the community.

30 Currently, in Victoria, the community based mental health support and recovery system has been significantly diminished. This means that much of the demand presents directly to the emergency departments, which is the most costly part of the health system. Therefore, investment in prevention and early intervention stages will reduce the demand and costs at the crisis end of the mental health system.

Question 3: Commissioning strategies from Victorian and Australian Governments have progressively sought consortia models to procure the scope of services required in complex human service programs. Given your collective experience across a range of sectors (Health Services, Community Health, Primary Health Networks, private hospitals), can you please outline the strengths and weaknesses of consortia as a commissioning approach?

31 There are many strengths of consortia as a commissioning approach. In Victoria, we need to think of the common client: there are several service providers in the health care system who are essentially caring for the same person. However, the various service providers care for and treat that person as an individual rather than a common client. The benefit of a consortia is that it brings together several service providers around a common client and focuses on the care and the outcomes for that client. It brings multiple focuses to increase skills and experience. There is an opportunity to share power and put the client at the centre. It clarifies responsibility within the healthcare system, emphasises that each service provider has a duty of care and effectively builds great referral pathways.

32 The weaknesses are that it can be quite time and resource intensive, and expensive. We need to think about how we achieve those outcomes more efficiently and more effectively. This requires bringing a whole range of service providers together in a consortia model around a common client. It requires excellent collaboration and partnership skills. It requires service providers to leave their ego at the door and really prioritise the benefit or outcome for the client over their own values or loyalties to their

organisation. It is really about the consortia being able to hold the vision for the outcome, rather than having the organisational drive behind what they say.

33 Responsive governance is important in a consortia model. Partners who are committed to the program/project and who can respond to the needs of the program where critical milestones or issues appear and pivot their availability and the organisation's response as needed.

Question 4: What do you think are the most significant issues facing community mental health workforces?

34 The community mental health workforce is facing several issues. Firstly, the changing policy and funding landscape in Victoria. Over the last three years, as a result of the Victorian community mental health system transitioning across to the National Disability Insurance Scheme (**NDIS**), we have lost a significant portion of our skilled and experienced community mental health workforce. If a community-based model was introduced, rebuilding that lost workforce will be critical.

35 Secondly, we need to develop a more diverse workforce; a workforce that reflects and meets the needs of a diverse community and also has an expanded scope of practice.

36 In relation to a workforce that reflects the needs of a diverse community, cohealth has been doing a lot of work to understand the communities that we work with, in terms of what those communities look like, both from a socio-economic perspective, and through a cultural lens. That is, identifying the cultural backgrounds and identities of the communities we work with. At cohealth, we attempt, as much as possible, to ensure that our workforce reflects the communities that we serve to bring a level of cultural safety into the workplace. For example, if a client of Sudanese or Burmese background attends one of our clinics, they see one of their own people. Or, if someone who has been unemployed long term, has alcohol and drug issues, walks into a clinic, they should work with a peer worker who has the same kind of social experience or background. This is about breaking down barriers between client and care provider. We have seen that when people walk in the front door and see their own people, or people they can feel comfortable with, it breaks down the barriers between client and care provider, and the client achieves much better outcomes.

37 A workforce with an extended scope of practice is a workforce that has the appropriate skills for the level of care required. For example, in health promotion and prevention, you do not need a highly skilled mental health clinician - health promotion officers or allied health assistants, skilled and trained in delivering mental health initiatives are sufficient.

38 Whereas in early intervention for those with mild to moderate levels of illness, a right workforce is critical, so people with lived experience of mental illness are very important. In the mental health services that we deliver, a peer coaching model has been extremely effective in supporting people with mental illness. People with mental illness respond extremely well to hearing a peer's story of how they were able to recover or stabilise their mental health. This is more effective than a clinical practitioner saying 'this is what you need to do'.

39 However, as you move along the continuum of severity and complexity, the more you need highly trained staff such as counsellors, psychologists and community mental health workers who are skilled and trained in mental health, but who are still not at that pointy, really clinical end.

Question 5: The Commission's interim report anticipates that '[a] contemporary workforce will be required to work in a diverse range of settings, with a greater emphasis on online services'. What is needed to help build and develop a workforce that meets these requirements?

40 In terms of technology, people increasingly want online interactions, such as video conferences. People don't necessarily want to walk into a big clinic and sit in a waiting room and have a more traditional model of service. The workforce needs to be able to work in different ways in order to engage most effectively with people, particularly young people who have different expectations around service delivery and online services. In order to accommodate this, we need a workforce that can work in contemporary spaces. That being said, the modalities used to provide services need to be able to respond to the particular preferences of the person seeking them. While some will prefer online interactions, others will prefer face to face contact. The system will need to ensure that moves towards online service delivery do not come at the expense of face to face options for those who prefer that approach.

41 In response to COVID-19 most of our services are now on-line or telephone and the system has adapted very well. Our clients remain engaged and report liking the modality and often find it easier and more engaging. Our experience shows that fewer clients miss appointments and conversations are deeper with better outcomes achieved more quickly.

Question 6: The service model used in Trieste in Italy appears to adopt a unique approach to the delivery of mental health services and a unique service configuration. Based on the information the panel has received about the Trieste model:

a) To what extent do you think this model could be successfully implemented in Victoria?

42 The model in Trieste involved replacing psychiatric hospitals with a network of 24-hour community mental health centres. This is possible in Victoria – it comes back to the consortium model and key principles around individualised care planning, active negotiation and comprehensive responsibility in our community mental health centres.

43 Whilst a community mental health centre, such as those in Trieste, would be effective in Victoria, there is a need to expand the knowledge and training of the general health care workforce in order for this model to work. For example, if a person attends a dental or podiatry appointment, if those clinicians can identify signs of mental illness, they can refer along an appropriate pathway. It is a more integrated model and something that cohealth has always provided. Having a large, multidisciplinary service across a diverse geographical area allows a clinician who identifies early signs of challenges to mental health to make a warm introduction to the client to our mental health service or to a General Practitioner (**GP**) who can develop a mental health care plan.

44 Therefore, having community mental health centres is ideal, but is further along the continuum. Having a broader health workforce skilled and trained around mental health would significantly improve outcomes and also deal with the demand issues.

b) Do you consider there are any cultural, contextual or setting differences between Trieste and Victoria that could limit the application of the Trieste model in Victoria?

45 Trieste is a much smaller geographical area to Victoria and has different system of government, but with the right investment and policy settings, the Trieste model could be adopted in Victoria. An advantage in Victoria is the network of community health centres that would be an ideal platform to establish a community mental health model.

46 Principles of keeping people away from large hospitals and institutions are always good, as is focusing on multiple needs, on the right care pathway, and building that in a hub or a 'one stop shop' with integrated multiple teams in the community where people live. Therefore, there are elements of the Trieste model Victoria can implement, but scope and scale it for the Victorian context.

47 Some aspects of the Trieste model exist in parts of our system, however there is not enough or an identifiable system that a person can find. ie; PARCs (Prevention and Recovery Care services), CCUs (Community Care Units), SECUs (Secure Extended Care Units) and in-patient care are all components. However, there is very little community psychosocial support coordinated in area-based services, nor long term housing, organised peer-activities etc. With the right investment this could be put in place. The policy setting, the governance and the investment would need to be to be right to enable the model to be effective.

48 We would need investment in those missing areas to enable of system of interventions starting with housing security and community support in smallish localities. Two to four LGAs would enable people to know what services and supports are available and how to access community hubs. Small wait lists and access to all parts of the system are required.

49 Shared governance with acute and community-based care is possible and should be the goal with clear accountabilities for the group.

c) What are other examples of unique community mental health models in other jurisdictions that are having a positive impact on consumer outcomes?

i. What are their key features?

50 There is the chronic care model, which is a model that has been shown to improve medical and psychiatric outcomes for people with mental illness in the primary care setting. cohealth described this model in our submission in response to the Productivity Commission's Draft Report on Mental Health.[1]

51 In this model mental health care and primary care (medical, nursing and allied health) are integrated. A co-located care manager provides counselling and education to clients. The care manager also works with clients on self-management and monitoring the outcomes of care that they are seeking. Along with a co-located care manager, a mental health specialist is also co-located in the same site and provides specialist consulting support. The care provided is across the continuum from the most basic level, up to specialist care as required. While each model is slightly different, there are some key features around comprehensive screening for mental health and chronic illness together with immediate or very short-term access to services. These are warm referrals, same day appointments, integrated multidisciplinary teams, care planning,

[1] cohealth submission to Productivity Commission draft report into mental health, January 2020 https://www.cohealth.org.au/wp-content/uploads/2020/01/cohealth-submission-Productivity-Commission-draft-report-into-mental-health-2020.pdf

care planners providing services and interventions. Importantly, the support provided is not limited to only coordination.

52 A key feature that should be considered in terms of the new system is the availability of self-management programs. When considering early intervention and changing demand, enabling people to self-manage is a key requirement. People need to be supported to know what they need to do to look after themselves and their mental illness – this will significantly reduce the demand on mental health services.

INDIVIDUAL QUESTIONS

COHEALTH

Key features of cohealth's service model for mental health services and the target cohorts

53 The key features of cohealth's mental health services are described below:

Forensic mental health in community health

54 This is a new service for people who have mental health treatment conditions on a community corrections order. The service has been running since December 2018 and receives State funding through the Department of Health and Human Services (**DHHS**). cohealth provide a brief mental health treatment of 4-8 sessions to clients who have a moderate mental health condition and have committed a range of offences. I describe this service fully in paragraphs 142 to 154, in the section on Forensic Mental Health.

The Western Psychosocial Support Service

55 This is funded by the Primary Health Network (**PHN**). It provides psychosocial support for people over 16 years living with severe mental health issues who are not eligible for the NDIS and live within the North Western Melbourne PHN region. Depending on the needs of the person, the length of support can range from 8 weeks to 12 months. It is designed to help those people achieve the best possible mental health and life outcomes. Using an evidence-informed, recovery-focussed approach, consumers spend time with an experienced mental health support worker to learn strategies and develop skills to help them build independence and improve their wellbeing. Ideally this period of support would be longer than 12 months as the engagement period can take some time to build trust.

The Early Intervention Psychosocial Support Response

56 This supports consumers with a mental health diagnosis in clinical services to engage with the NDIS. This service was implemented post the decommissioning of the

community mental health service and before individuals could access NDIS. It supports people around their mental illness in the short term, but also helps them to transition to NDIS services. It is funded by the Department of Health and Human Services, through Melbourne Health. The initiative provides short to medium term, specialist psychosocial support to help clients to: build their capacity to better manage their mental illness; develop practical life skills for independent living and social connectedness; achieve healthy, functional lives; and if eligible, transition to the NDIS.

57 Priority of access is given to eligible clients who are hard to engage due to the nature of their mental health condition and/or who are experiencing homelessness, multiple disadvantage, are at high risk of suicide or self-harm, and engaged in the youth and adult justice system.

Youth Residential Rehabilitation

58 cohealth's Youth Residential Rehabilitation program supports young people aged between 16 and 25 who have been diagnosed with a mental illness. It involves a 12 month stay in a residential service and is funded by DHHS. There are three facilities across the north-west of Melbourne.

Prevention and Recovery Care services ***(PARCs)***

59 PARCs are residential services that help people with mental illness who are leaving hospital or those who would benefit from a 24-hour support service to avoid hospitalisation. It is a step up, step down model. The PARCs are funded by DHHS, via Melbourne Health.

*Homeless Outreach Mental Health Service (**HOMHS**)*

60 This is funded by DHHS and is a clinical and community mental health case management service for people with severe and enduring mental illness and a history of chronic homelessness delivered in Melbourne's CBD. cohealth, as the lead agency, partners with three agencies to deliver the program – Inner West Area Mental Health Service who provide clinical mental health services; McAuley Community Services for Women who have specialist skills in engaging the growing number of women experiencing homelessness; and Launch Housing who provide links to stable and affordable housing.

61 The HOMHS interagency multidisciplinary team offers assessment, integrated clinical treatment, recovery support, housing support and care coordination, scaled in intensity to meet each client's needs, values and goals. Through this interdisciplinary and multi-agency approach, HOMHS improves access for clients to mental health services,

housing support – including stabilising housing - physical health care, and practical assistance.

Indigo

62 This program provides support coordination and occupational therapy service to clients who experience complex disability, forensic and mental health needs. It provides services to individuals who have funding packages from the NDIS, Transport Accident Commission and multiple complex needs, which are state funded by DHHS.

Exceptionally complex support needs programs ***(ECSN)***

63 This is a National Disability Insurance Agency (**NDIA**) funded service designed to enable programs or service providers to respond to individuals in crisis situations who cannot be supported through regular NDIA or other mainstream services. ECSN will work closely with NDIS providers as well as mainstream services (hospitals, police, mental health and justice services) to enhance the sector's capability in responding to and supporting NDIS participants with exceptionally complex support needs. It is a state-wide program with three key functions: sector and community development activities; subject matter expertise activities; and crisis referral response activities. The NDIS participants may include those with very complex support needs; or those whose circumstances are very complex, for example, those that change suddenly and unexpectedly, say in the event of illness or death of their primary carer. This two-year program is currently in the initial engagement/establishment phase.

Mental health nursing program

64 This is funded by Medicare through the PHN and focuses on how people experiencing moderate mental illness can be supported to be well in the community. GPs refer clients to our mental health nurses who provide mental health support and counselling services and support in liaison with the GP.

General Practice

65 cohealth GPs also provide mental health care plans and other mental health support to patients. This is funded by Medicare and other mental health services. Care plans may include psychology or counselling referrals or chronic disease plans for physical health issues.

cohealth's work with primary care and other health services

66 As a primary health provider, cohealth is able to closely integrate physical and mental health care within our own service. Mental health programs can refer consumers to

GPs, practice nurses, oral health services, allied health, AOD services and group programs. Where appropriate, they work closely with the Aboriginal and Torres Strait Islander health and refugee and asylum seeker health programs. This is done as a warm referral, and consumers are often directly introduced by the mental health worker in the first instance. Mental health nurses are also embedded in some of our medical clinics. At the same time, these other health practitioners who identify mental health concerns with their clients can draw on the expertise of the mental health workforce to support their work with clients who have mental health conditions.

67 We also have close working relationships and referral pathways with clinical mental health services and other health providers. Some of these have formal arrangements in place, others are less formal, but are nonetheless strong, working relationships.

CURRENT ROLE OF COMMUNITY HEALTH SERVICES

Key distinguishing factors between community-based settings and hospital settings

68 As noted above, as a primary health provider, cohealth is able to closely integrate physical and mental health care within our service. People can be provided with care in their own homes, by telephone or within a community facility, as a less clinical environment. These services include specialist mental health services and psychosocial support. cohealth's experience is that community-based settings are much more comfortable for consumers than hospital settings. Community-based settings focus on the whole person and not solely the presentation of the mental health condition. It is a recovery-focused approach that focuses on long term self-management, rather than treatment alone. That is achieved by focusing on the goals of consumers and how to work with consumers to achieve them.

69 In my experience, hospital-based mental health services are significantly stretched and only have capacity to focus on the mental health condition, not rehabilitation and long-term self-management. It has also been our experience that community-based clinical mental health services – the community components of Area Mental Health Services – are also often overstretched and have limited capacity to provide the recovery-oriented psychosocial rehabilitation support needed by people with serious mental illness. We have also found that the potential for involuntary treatment in clinical services – whether based in a hospital or community setting – can be a barrier for consumers.

70 Non-clinical psychosocial recovery support programs incorporate the time and skill sets to engage holistically with the person's needs, including their social circumstances and lifelong recovery strategies. These services are an essential complement to clinical work. Formal partnerships with clinical services mean that clinical services can use their

limited resources to work with people in an acute phase, while the psychosocial recovery-based supports provide continued community support to people whose mental health is relatively stable.

71 This partnership approach is critical to good outcomes.

The appropriate setting for particular types of care, treatment and support in a future mental health system

72 Attending a major acute hospital is a significant barrier to people experiencing mental illness. Having to walk into a big building and being confronted with all of what is happening – the noise and busyness of an emergency department, having to wait for often substantial periods of time – is completely overwhelming, so people will choose not to seek the care they need to avoid walking into a hospital setting.

73 It is only treatment and care of the most acute mental illness presentations that should be treated in hospitals. That is, only when a person's health care requirements or mental illness mean that they cannot be supported living within the community.

74 If we think about the severity of mental health challenges as a triangle, it is the tip of the triangle where people are most unwell – it is only that portion who should be treated in hospital. The second or third tiers of the triangle should all be able to be managed effectively in the community if we have an effective community based mental health response. This also reduces the need for acute services as changes in a person's condition – which may require a change to care or treatment – are identified early and then can often be well managed in the community.

Current services and programs that improve consumers' mental health outcomes

75 I can comment on the programs offered by cohealth. We consider that all the mental health programs we offer are effective in improving consumers' mental health outcomes. I will share examples of some of these programs.

76 cohealth's Homeless Outreach Mental Health Service which is based in the Melbourne CBD is an example of a very successful service. cohealth has data which demonstrates the outcomes each individual has achieved, and we have also been able to demonstrate a reduction in hospital emergency department presentations. Examples of positive outcomes from the program include: 86 per cent of clients who were placed in stable housing have maintained it long term; 46 per cent were linked to a GP where they previously weren't; and there was a 42 per cent reduction in emergency department admissions. The program's success in improving health and wellbeing lies

in the intensive support provided to clients with particularly complex needs, combined with the joint clinical and community mental health supports and other support structures, including housing services.

77 Attached to this statement and marked '**NB-2**' is a copy of the Homeless Outreach Mental Health Service cohealth poster that contains further data.

78 The current model for the PARC service is also very effective in terms of being able to provide 24-hour support and avoid hospital presentations. Some of our other programs are newer, such as the forensic mental health program. This has only been operating since December 2018, but we are seeing good engagement with that community cohort and we are beginning to see good outcomes.

79 In terms of outcomes, we have been able to link clients with health services within cohealth including GPs and dental. Many clients are not ready to engage in a therapeutic intervention, however, we have been flexible in providing aspects of mental health case management, working holistically with the range of presenting issues and clinical goals/needs that clients present with. While the program is pending formal DHHS evaluation, we receive ongoing feedback from clients that it has provided the first opportunity to be listened to, the first opportunity to consider the impacting factors upon their mental health and the first time they have not been judged. Overall, we have provided interventions that are addressing poverty, substance use, trauma, lack of access and understanding of services and family violence and disconnection.

80 We have also seen good outcomes for our Youth Residential Rehabilitation services, which aim to help young people to achieve their recovery goals. This service was independently reviewed in 2017 and found that it is having a significant positive impact on the life domains of the young people. In particular, the young people participating in the program at the St Albans site reported a significant improvement in all domains, with 'considerable' improvements in: Living Skills, Work, Relationships, Responsibilities, Identify and Self-esteem. Across the program, more than 50% of young people have made a significant improvement in seven of the ten life domains (Managing Mental Health, Physical Health and Self-care, Living skills, Social Networks, Relationships, Responsibilities, and Identity and Self-esteem). Improvements implemented following this review have further improved outcomes for young people in the services. Sally's story, in cohealth's submission in response to the Productivity Commission's Draft

Report on Mental Health,[2] provides a good example of the outcomes achieved for young people in the program.

Current services and programs that are not operating at their full potential

81 Funding arrangements can work to inhibit the full potential of services. Silos, multiple funding streams, reporting requirements, and different outcomes expected all restrain services working from working in the integrated manner that will provide the best outcomes for consumers.

82 For example, our AOD services receive 22 different types of State and Federal funding. These services span the continuum of response from health promotion to harm reduction to treatment services. In an attempt to overcome the restrictions of this funding complexity, cohealth is working with the Department of Human Services on a quality improvement project to integrate funding streams. The aim is for our services to become more impactful and outcomes focussed, ensure we were meeting community needs, and that services are evidenced based, responsive and codesigned.

83 It would be useful to explore approaches such as this to improve mental health outcomes.

84 Funding changes in recent years, particularly as a result of the introduction of the NDIS, have impacted on the delivery of services, through the upheaval to consumers, workforces and programs. There is reduced capacity in consumer directed funding models for the training, reflective practice and workforce coaching that is such an important foundation for effective service delivery.

85 It is also important to acknowledge that other social circumstances beyond mental health have a significant impact on mental health outcomes. In particular, poverty and lack of appropriate housing can limit the effectiveness of services and programs to improve mental health outcomes.

Community Health Services provide an ideal platform for community-based psychosocial rehabilitation

86 cohealth – and other community health services – provide a wide range of physical health services and social support services in addition to mental health services. As such, community health services can provide integrated, wrap around support that

[2] cohealth submission to Productivity Commission draft report into mental health, January 2020, p 19: https://www.cohealth.org.au/wp-content/uploads/2020/01/cohealth-submission-Productivity-Commission-draft-report-into-mental-health-2020.pdf

responds to the holistic needs of the person. At cohealth, the services provided in addition to mental health programs include (and are not limited to):

a) GPs & nursing;

b) Public oral health;

c) Allied health – physiotherapy, occupational therapy, exercise physiology, podiatry, dietetics;

d) Aboriginal and Torres Strait Islander Health and Refugee and Asylum Seeker Health;

e) Alcohol and other drug programs, including two Specialised AOD Primary Health Services; and

f) Social support programs – family violence, child and family services, homelessness, victim's assistance program, social inclusion programs, and the like.

87 As such, community health services operate as service hubs and are in the unique position of being able to link mental health support with physical health and social support programs – working with the whole person in an integrated, wrap around manner.

88 Strong formal relationships exist with clinical mental health services and other specialist providers and provide strong pathways of care outside of the community health offerings.

89 We know that people with mental ill health also have poorer physical health, and experience disadvantage. Many have trauma backgrounds and other co-occurring conditions/circumstances. Providing holistic, wrap around services provide a better outcome for consumers.

90 Community health services are locally based and experienced in working with communities to tailor services and responses to the particular circumstances of the local community. In addition, they are an existing state-wide network that could be leveraged to create a universal, accessible gateway to the mental health system.

The factors that distinguish Community Health Services from other providers

91 It is this diverse array of physical health and social support programs, in addition to mental health services, that distinguishes community health services from other

providers, such as specialist mental health not-for-profits and area mental health services, which focus primarily on mental health.

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

92 The key to self-management is being both responsive and flexible to the needs of the individual. It requires flexible funding, or some brokerage funding, which allows a service provider to provide an individual with an immediate response – that is very important. The response needs to be available when the consumer needs it and where they need it. The support should be able to reduce the frequency in which people are unwell and identify any decline in their condition.

93 Support needs to be provided by workers who are trained and have experience in mental health, particularly with a recovery orientated approach. A peer workforce is really valuable and provides opportunities for social connection. With the people who we work with, cohealth sees a significant level of social isolation as a result of both the stigma related to their mental health condition and negative side effects of medications. Providing opportunities to increase social connection is extremely important in the recovery process for a person with mental illness, and also provides great support for people who care for those with mental illness. It gives the carers the ability to connect with clinical services as soon as the condition declines. Therefore, having that relationship connection pathway into a clinical mental health service through a peer is extremely important.

Barriers to increasing the volume of community mental health services

94 Funding is key to meeting demand and demand has always outstripped service capacity. This has been exacerbated by the transition of the community mental health service funding to the NDIS. Psychosocial rehabilitation support in particular, has been lost in that transition and that is where the funding needs to be addressed.

95 We also need to be able to re-engage and upskill the workforce that we have lost over the last three years to enable them to work in a contemporary way.

The role of consumer choice in determining the volume and type of care

96 cohealth comes from a perspective of consumer choice and having the consumer central to determining the type of care they require and where they require it. We need to acknowledge that the consumers are the experts in their own lives. From a consumer perspective, it is really putting them central. The consortia model is effective in coordination through having the common client - that enables the consumer to be central to the care that they receive.

The merits and challenges of a 'single care plan' approach to coordinating services

97 There is some appeal to a 'single care plan' approach as it aims to ensure that all involved are fully supporting the consumer and that the individuals involved have the same information and shared clarity about consumer goals. What is important is that it should not be at the expense of the consumer's right to choose and control the services and the health care workers that they access and want more information from. Consumers should also be able to retain control about which services and workers their information is shared with. This could be difficult under a 'single care plan' approach.

98 The Multiple and Complex Needs Initiative (**MACNI**) model provides good examples of this approach with a single care plan and multiple providers contributing to the overall outcomes with the client.

Mechanisms to improve people's ability to identify and navigate to the right mental health care, treatment and support

99 There needs to be a range of mechanisms to respond to the needs and preferences of different individuals or different groups. For example, for people with serious mental illness, our experience has indicated a need for a service navigator/advocate/care coordination function that assists people to identify what their needs are and to navigate the broader system.

100 A jurisdiction with a good model is the Netherlands. Local neighbourhood health centres offer the community that is served by the centre enrolment into a government funded model. Every designated geographical area has what they call a Neighbourhood Healthcare Centre. The Neighbourhood Health Centres are not too dissimilar to a community health centre, the difference is that community health centres cover much larger geographical areas. Neighbourhood Healthcare Centres provide primary healthcare services, such as oral health, allied health services and general practice, alongside mental health services, such as community health workers, social workers, counsellors and psychologists. This is a great model of localised basic healthcare services that people can easily access.

Specific types of care/services the mental health system should deliver to children and young people and their families and carers

101 Resourcing is a significant barrier in this space - parenting programs overall are not well resourced. cohealth's experience is that when people are unable to obtain the mental health support they need, other supports step in to provide this, even if it is not specifically the role they are funded for. In the case of cohealth's parenting programs,

these workers find that they may be providing mental health support freely to the parent, which limits their capacity to provide parenting support more generally. They find that they are pseudo-mental health workers and that work is not funded. The parenting program is funded, but not for the more specific mental health support that is being provided. It is that specific mental health support that parents are requesting and therefore there is an issue of knowledge integration.

Key barriers to effective family and parenting support programs

102 The key barriers are described in the previous paragraph.

Supporting individuals, communities and groups with intersectional strengths and needs to access high quality, suitable universal mental health services

103 Ensuring that people with lived experience, and organisations that represent a wide range of different groups, are central to the design of services, and processes to access them.

MULTIDISCIPLINARY CARE/CARE COORDINATION

What is needed for Community Health Services to deliver multidisciplinary care

104 Reorientating service delivery and funding approaches, along with additional funding commitment to provide such a service, is needed in order for Community Health Services to deliver multidisciplinary care. We have developed a proposal for such a service, and it is outlined in our submission in response to the Productivity Commission's Draft Report into Mental Health entitled - *Community Mental Health – a vision for integrated primary and community mental health.*[3]

105 Key features of this proposal, include:

a) An inter/multidisciplinary team: mental health teams (counsellors, psychologists, mental health nurses, AOD workers, social workers and mental health workers) join existing multidisciplinary allied health teams in community health services;

b) Care coordination: care coordinators oversee and support access and coordination for people with chronic and complex support needs;

c) Integrated and comprehensive assessment;

d) Step up mental health support; and

[3] cohealth submission to Productivity Commission draft report into mental health, January 2020 https://www.cohealth.org.au/wp-content/uploads/2020/01/cohealth-submission-Productivity-Commission-draft-report-into-mental-health-2020.pdf

e) Same day response.

Recommended changes to governance arrangements

106 Effective governance is extremely important, but that requires adequate resourcing to ensure that there is an effective governance model in place. Effective governance requires collaboration between all the service providers working with a consumer. It takes significant time, resource and partnering to establish an effective governance model for a consortia. This work is unfunded.

107 A clearly articulated model would guide the governance arrangements. At present most cross partnership program funding is dealt with through Memorandum of Understandings between organisations. This works reasonably well but is predicated on a siloed system. A well-functioning integrated system builds governance to meet the needs and accountabilities it proposes.

108 An integrated system of care could see local providers develop appropriate governance in line with the needs of their local area in concert with consumers. Building governance from the ground up is challenging but would enable a truly local solution for local needs.

The strengths and weaknesses of colocation models

109 cohealth is always looking at opportunities to be co-located with other service providers. We have a number of hubs across the north and west of Melbourne where we are a partner, rather than a tenant. In this framework, cohealth brings a wide range of physical health, mental health and social support services to the facility. The services are identified by the community the hub serves. The local council is the lead organisation in that facility, but then it co-locates services such as a childcare centre, kindergarten, maternal child health nurses or a library, a paediatrician and general practice. A strength of this model is that it enables the effective engagement of people who might access the library or the childcare centre, but who normally would not access a health service. It gives service providers opportunistic time to engage with young people and parents, but then also to work with the other care providers that are in the partnership around the common client. It is a very effective model of working.

110 Other strengths are that it reduces the isolation for healthcare workers. Working with peers substantially increases satisfaction at work, along with retention of staff in the workplace, which is vital amongst mental health care workers.

111 However, this model requires effective partnering, which relates to governance and having a clear purpose and vision that is shared amongst all the relevant service providers, and shared planning and responsibility. It also requires common information technology (**IT**) systems and sharing of information to be effective.

112 Colocation that solely involves locating services at the same site, but without any governance arrangements to ensure there is organisational commitment to work closely together, is unlikely to have the greatest benefits for consumers that lead to better outcomes.

Programs that provide integrated and collaborative approaches and continuity of care

113 I am a really strong advocate for community health as a state-wide platform. Victoria is unique compared to other states in having a state-wide community health service network. This provides an ideal platform for the delivery of integrated community based mental health services across the State. Such a model has the potential to provide continuity of care right across Victoria, with the right IT infrastructure. For example, if a person attends our clinic at Footscray, they could receive the service they need there. Equally, if they were on holiday in Lakes Entrance and needed support, they could attend the community health service in the area - Gippsland Lakes Complete Health - and would be sure to receive continuity of care in terms of their record and care plan.

114 The state-wide community health service network provides a unique platform to be able to scale and deliver community based mental health services that provide the right care at the right time and in the right place. The client would not need to attend Footscray to see their worker, unless they wanted to, or they could use an online service. Equally, they could just walk into any community health centre and receive the support they need. They would have more choice and better access to services.

FUTURE ROLE OF COMMUNITY HEALTH SERVICES

Vision for the role of Community Health Services in the mental health system of the future

115 Community health services have the potential to have a pivotal role in the future of a mental health system. Our ability to employ and engage multidisciplinary teams and have mental health care work as part of that team, and to integrate physical and mental health and wellbeing and social support, is a unique opportunity.

116 The evidence for people who experience long-term mental illness shows that their physical health outcomes are significantly poorer than that of the general population. Usually, when a person with mental illness visits their healthcare provider or GP, the physical condition is often overlooked because there is a mental illness. They are told, for example, that they don't have chest pain, rather that they are anxious or depressed. As a result, their physical health is worse compared to that of someone who does not

have a mental illness. Community health could play a unique role in integrating physical and mental health and wellbeing.

117 Community health services have a common aim – to provide locally-based, affordable health and social care to disadvantaged Victorians. The sector is a critical part of Victoria's healthcare system. The models or services provided by community health vary across Victoria. This is because each community health centre is tailored to deliver services that meet the needs of the local community and no two communities look the same in Victoria. cohealth's 34 sites across the north and west feel very different because they are focusing on different community needs. Therefore, in terms of designing and delivering mental health services, they should be designed locally with local consumers and users to ensure the service reflects what the community needs. That is a key strength of the community health platform that exists across Victoria.

118 Community health also has a history of engaging with local users and using peer workforce which grounds the work in the actual experience of the people seeking the service.

119 Providing integrated physical and mental healthcare in local communities, particularly for those people who experience disadvantage and marginalisation, is our vision for the future of Community Health Services in the mental health system.

The governance and funding arrangements for this vision

120 Funding models need to shift towards focussing on outcomes and providing services with greater flexibility in how they use funding to achieve outcomes. We need to move away from siloed funding approaches. Our proposal *Community Mental Health – a vision for integrated primary and community mental health*, outlined in our submission in response to the Productivity Commission's Draft Report into Mental Health, describes a funding approach to meet this vision.[4]

121 **Other governance** and funding **arrangements needed to support this vision are outlined elsewhere in this statement.**

How Community Health Services can maximise the impact of Commonwealth funded services to improve mental health outcomes for Victorians

122 Community Health Services are already doing this well as demonstrated by the list of mental health services that cohealth helps deliver. A number of those services are Commonwealth funded. The approach that we take is to consider what the needs of the

[4] cohealth submission to Productivity Commission draft report into mental health, January 2020: https://www.cohealth.org.au/wp-content/uploads/2020/01/cohealth-submission-Productivity-Commission-draft-report-into-mental-health-2020.pdf

community and client are and then look at what funding sources are available, both at the State and Federal levels, to provide support to the client. In that way, cohealth taps into the Commonwealth funding through the PHN's, and Medicare benefits schemes.

123 Within our oral health services, cohealth accesses the Child Dental Benefits Program and the National Partnership Agreement. By drawing on these funding streams from the Commonwealth, we can provide a much greater service offering and thereby maximise the Commonwealth funded services to improve mental health outcomes for Victorians.

WORKFORCE

Factors that enable community mental health workers to work from a recovery-oriented, coaching approach

124 We have found that an embedded system of training, workforce coaching, reflective practice and the inclusion of a peer workforce of people with lived experience of mental illness all contribute to working from a recovery-oriented approach. An organisational commitment to the approach is key to ensuring that all mental health programs work in the same way.

125 All cohealth mental health workers are trained in the Collaborative Recovery Model (**CRM**), which is based on working with a coaching approach with consumers to identify their strengths, values and goals for recovery. Training provides the foundation for working within this model, but embedded 'booster sessions', are needed. These are shorter sessions with a smaller number of people where the trainer can focus workers on the questions that have arisen for them when they have been using the approach in practice.

126 Workers also participate in workplace coaching, ideally once a month. This mirrors the approach taken with CRM so workers are able to experience the approach themselves, for example, identifying strengths, values and goals. Reflective practice is another important feature, where workers focus on the impact and effectiveness of their practice in a group setting. Using a group coaching approach, workers decide what aspects of practice they would like to reflect on.

127 A peer workforce of people with lived experience is also embedded into teams and supports the recovery-oriented approach through consulting with staff and working with consumers.

Embedding a recovery-oriented approach – training approaches and workplaces practices

128 Mental Health Victoria has an important role as the peak body to provide training and to set standards and support the sector to meet those in their workforce.

The Indigo multidisciplinary team

129 cohealth's Indigo program is a specialist program providing assessment and care plan coordination for clients with multiple and complex needs. Program components include the MACNI; NDIS care coordination; and TAC clients. The work of MACNI will be used to describe the key features of providing integrated service responses to people with complex needs.

130 MACNI is a DHHS funded support coordination program that is focused on supporting people who experience complex needs that intersect across a range of service sectors. Participants of MACNI usually have a lived experience of all of the following: a mental illness, an intellectual disability or Acquitted Brain Injury, alcohol and other drug use and a involvement in the justice system. Referrals to MACNI usually only come once a person and their care team have exhausted all mainstream options. cohealth's service model for MACNI participants involves a team of highly experienced staff, known as care plan coordinators, from multidisciplinary backgrounds (usually a combination of social workers, occupational therapists and nurses) working from a holistic, person centred framework. The support coordination they deliver takes a big picture view of service delivery and works both with the participant as well as behind the scenes with service providers to facilitate an integrated model of care. The MACNI care plan, which is developed with the input of all service providers before any action is taken by the care plan coordinator, is key in supporting outcomes as it brings together service providers from different sectors that often have competing views, priorities and frameworks.

131 In order to achieve outcomes for participants, care plan coordinators must have a highly detailed knowledge of the mental health, disability, forensic, housing, welfare, emergency services, primary health and AOD service systems. Knowledge of these systems, their strengths and limitations gives care plan coordinators the ability to come up with innovative solutions for participants that draw on the strengths of each of these services systems. By taking a big picture view of things, care plan coordinators are able to work with the care team, participants and their carers to identify gaps and duplication in the care team to ensure the right mix of service providers are involved to achieve the best possible outcomes. However, this view also places them in a unique position to see the limits of these systems and they are often working right on the boundaries of what is possible. They also come across situations where they know of a solution that

exists in one system, but for reasons of eligibility are not accessible to a person who would benefit from them.

132 Another key to MACNI's success is how well it is resourced. The assessment phase is funded at 20 hours a week for between 4-12 weeks and care plan coordination is funded for between 4-12 hours a week for up to three years. Outcomes and care plan progress are recorded on a 6 month basis per participant and reported back to a panel of senior professionals from across the service sector and DHHS. The panel also supports problem solving, cross sector buy-in and innovative solutions. Client outcomes are based on individual client circumstances and are very positive over their journey with MACNI.

COMMISSIONING

Lessons from the experience of the NDIS implementation

133 cohealth is very supportive of the NDIS principles of giving choice and control to consumers. However, the needs of the most vulnerable and marginalised are not well met in the NDIS consumer directed funding model approach.

134 Consumer directed approaches assume a degree of self-agency or ability to advocate for self or negotiate complex systems, but people who are vulnerable are not always able to do that. Therefore, the complexity of the system prevents people getting the assistance they require when they need it, and is not well suited to their fluctuating needs. For example, if there is a change in a person's health circumstances, the NDIS plans are rigid and do not allow them to 'step up or step down' as they might need.

135 cohealth's key learning from the experience of NDIS is that it is a very complex and rigid system that does not support or enable vulnerable people to do well and thrive. Because it is rigid, it is not responsive and flexible in terms of what the person's needs are at any given time.

The impact of a competition-based approach on service integration

136 A competition-based approach has a negative impact as competition means that service providers or organisations are competing on price and offer the lowest price. It means that the skill of the workforce delivering the service or the quality of the intervention is significantly reduced. cohealth has a qualified, highly experienced workforce that cannot deliver the service at an 'NDIA price'. In order to deliver the service at the NDIA price, you cannot use the existing workforce and must employ people who are not as skilled, trained, experienced or qualified to deliver the care. The quality of care and outcomes for the client are significantly impacted because an unskilled worker is delivering the service. It is detrimental to integration because it promotes a commercial business

model, rather than the approach that cohealth advocates for, which is having the common client at the centre and working together for the outcomes of a client rather than a business.

Improvement to outcomes and efficiency through greater market competition in the delivery of mental health services

137 The starting point should be looking at the desired outcomes and effectiveness (rather than efficiency), then look to the model/s of service delivery that best meets those needs, rather than assuming that competition is the path to achieving this. Market competition tends not to meet the needs of the most vulnerable and disadvantaged people in our community.

Risks of introducing greater market competition

138 The risk of introducing greater market competition include market failure, underqualified providers, cost reduction, and quality and safety can be less regulated. There is also less incentive for services to work together – despite our knowledge that collaborative approaches have the best outcomes for consumers.

139 The NDIS has shown that providers seek the least complex clients to support as it is more cost effective and the workforce needs less training. This is a high risk strategy in mental health.

The role of State and Commonwealth Governments in reducing fragmentation and improving consumer outcomes through commissioning

140 There needs to be better coordination between the State and the Commonwealth. This includes better definition of who is responsible for what and ensuring that those responsible accept and carry out their responsibility. For example, it is the State's responsibility to deliver a community based mental health service system. However, this does not mean that it does so in practice. Ultimately, it is the client that loses from this if there is no service in place.

141 The Commonwealth is not the best option for commissioning as it is too far away from local need. States should have a consistent approach, but be responsible for community mental health services in a potentially Commonwealth framework.

FORENSIC MENTAL HEALTH

Experiences from rolling out the Forensic Mental Health in Community Health Program

142 Rolling out the Forensic Mental Health in Community Health program has been an extremely valuable learning experience. It was not an easy program to initiate as it brought together a number of different providers. Therefore, it was really important to clearly articulate what the role was of the different providers and to clearly establish a consortium of the vision for the service.

143 The staff work across a Community Corrections catchment in the northwest metropolitan region of Victoria. The referrals come through a secure portal through Community Correctional Services **(CCS).** Mental health nurses then assess the referral, which includes the Community Corrections Order, and they facilitate a mental health assessment. The challenge of the current service model is that it was initially based around the expectation of clients attending cohealth sites. However, we quickly learnt that it was much more effective to enable clinicians to provide sessions from Community Corrections sites. In this approach, client appointments with us would follow sessions with CCS. It provides a level of safety, familiarity and security for clients to be in a familiar place. Often the clients we support have quite chaotic lifestyles, so if they only have to remember one appointment, and attend one location, they have the best chance of fulfilling their requirements. It also minimises their travel time. CCS managers and case managers have also reflected that having mental health workers on site is an invaluable resource for secondary consultation. At the same time, clients are given the choice whether they prefer to meet at our sites or CCS. Additionally, we have had significantly greater uptake and engagement in our telehealth with clients since we have moved to this mode delivery in the COVID-19 environment.

Engagement with Corrections and other agencies.

144 The key learning for us was how we engage with Corrections and other agencies. We had to do a lot of learning and collaboration in that space.

145 Engagement occurs at a governance, management and operational level. The cohealth manager attends team meetings at CCS sites across the catchment and is in contact with key staff from the central office of Department of Justice**.** Management meetings also occur between the cohealth manager and regional CCS managers across the North and West part of the catchment.

146 Upon referral, the initial engagement occurs with a Senior Nurse at intake. The Senior Nurse books in an assessment time with a respective CCS case manager to assess a

prospective client. There are ongoing discussions and meetings between cohealth clinicians and CCS case managers in relation to client progress.

147 We have worked on delineating roles with CCS and ensuring that we report anything pertinent but protect some of the detail of sensitive material in sessions to maintain a therapeutic context. There have been some challenges in relation to communication styles that have arisen, however CCS managers are keen to hear feedback when their staff take more punitive approaches to clients. Overall CCS have been welcoming and overwhelmingly collegiate and collaborative. Any issues arising are par for the course in any new initiative.

148 Given that we are working with moderate mental health conditions we have only engaged Area Mental Health Services in situations of crisis and had great buy in and follow up as required. We continue to consult with Melbourne Health for secondary consultation through their Mental Health-Forensic Interface Team, which has been invaluable.

The demand for the Forensic Mental Health in Community Health Program

149 This is an area where there has been a significant gap in our service system, the need is great. The service took some time to establish and start running. Now, we are seeing demand outstripping supply. We are seeing a significant number of referrals and an increased level of those referrals are engaging with and taking up the offer of services. The reason for this is effective governance, and the partnership model of collaboration – that is, everyone being of the same understanding and knowledge of common clients.

Number of offenders serviced

150 We have had approximately 550 referrals, we have completed approximately 440 assessments and have referred approximately 220 clients to clinicians for care.

Reflections on the effectiveness of the service

151 We have been able to link clients with health services within cohealth, including our general practice and dental services. Many clients are not ready to engage in a therapeutic intervention. However, we have been able to be flexible in providing aspects of mental health through a case management approach. This means working holistically with a range of presenting issues within the needs that the clients present with.

152 The service is currently pending evaluation from DHHS. However, we receive ongoing feedback from clients that this service has provided the first opportunity that where they felt listened to, where the factors impacting upon their mental health had been considered. We also receive feedback that it was the first time that they had walked into

a service and not felt discriminated against or judged because of their justice history. We consider that to be very rich client feedback.

153 We have also been able to provide interventions in issues that are far reaching, such as addressing poverty, substance use, trauma, lack of access to services, understanding of services and family violence and disconnection.

Recommended changes to this service

154 Having more ongoing support and treatment for clients would be beneficial as it would enable us to achieve ongoing rapport and better outcomes post-discharge. Additional resourcing would enable us to have greater coverage and better embedding of services at Community Correctional Services offices, which is where we find it most effective to initially have our staff. Additional mental health clinicians working in the system will also enable us to be more responsive to clients who present in an unplanned manner and have a more informed understanding of mental health services across the Community Corrections service.

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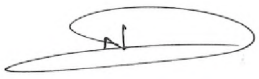

print name Nicole Bartholomeusz

date 09/06/2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NB-1

This is the attachment marked 'NB-1' referred to in the witness statement of Nicole Bartholomeusz dated 09/06/2020

Strategic Transformational People Leader Performance Orientated Authentic

Career Mission

A registered clinician, experienced senior executive and strategic thinker with a contemporary leadership style, combined with business acumen and strong financial management capabilities; I have a thorough understanding and commitment to delivering high quality value based healthcare for individuals and communities.

Key Strengths

- Registered clinician with senior executive and non-executive board director experience in the healthcare sector.
- Strategic and conceptual thinking through drawing information together to interpret complex situations.
- Leading through creating a shared vision, strategy and establishing a culture for continuous improvement.
- Outcomes focused through inspiring and coaching others to achieve.
- Build and sustain quality relationships through successful engagement and partnering.
- Drive to continuously improve through learning and acquiring knowledge and skills.

Career Summary

2019-present	Chief Executive Officer, cohealth
2016-19	Deputy Chief Executive Officer, cohealth
2014-16	Executive Director Corporate Services & Deputy Chief Executive, cohealth
2013 (6mths)	Interim Chief Executive Officer, Western Region Health Centre
2012-14	Deputy Chief Executive Officer & Company Secretary, Western Region Health Centre

Non Executive Board Roles

2019 (4mths)	Non-Executive Director, Western Health • Chair, Population Health Advisory Committee • Member, Cultural Diversity and Community Advisory Board Committee
2018 - present	National Council Member (elected), Australian Healthcare & Hospitals Association • Member, Board Nominations Sub-committee
2011-14	Non-Executive Director, Macedon Ranges North Western Metropolitan Medicare Local • Chair, Risk and Compliance Committee • Member, Executive Performance and Remuneration Committee

Professional Registration

- Dental Therapist, current registration with the Australian Health Practitioner Regulation Agency.

Professional Qualifications & Development

- Graduate, Australian Institute Company Directors, 2013
- Master Business Administration, La Trobe University, 2005
- Graduate Diploma Community Health, La Trobe University, 1996
- Diploma Applied Science (Dental Therapy), School of Dental Therapy, 1991
- Study Tour Models of Healthcare Delivery England and Netherlands, 2018
- Strategic Perspectives in Non-profit Management, Harvard Business School, Harvard University, 2017

- Victorian Healthcare Association Health Service Leadership Study Tour, 2015
- Company Secretary, Governance Institute of Australia, 2012
- Executive Coaching, Kru Consulting/Human Capital International, 2009 to present

Career Summary

Chief Executive Officer (CE) *September 2019 - present*

cohealth

Responsibility

As CE I have primary responsibility for leading and managing the Organisation to deliver cohealth's strategic objectives. Working in a highly complex environment that requires effective interaction with the Board, staff, communities, key stakeholders, government departments, partner organisations and peak bodies. I am highly motivated and possess the ability to see the opportunities for service development and improvement.

I provide leadership and oversight to cohealth's operational Executive Leadership Team, and am responsible for the strategy, planning and implementation of cohealth's service delivery, financial, corporate and people frameworks and plans. This includes ultimate responsibility for; cohealth's 950 employees, $70 million operating budget; $57.3 million dollars of assets; and ensuring the delivery of high quality, safe, patient centered care.

As the primary strategic partner and thought leader to the Board, I provide a strong voice guiding the setting of the Board's strategic ambition and ensuring that the Board meets its governance obligations.

Board Director (non-executive) *July 2019 to October 2019*

Western Health

Appointed to the Board, Western Health. Unfortunately, following my appointment the establishment of the new Footscray Hospital was identified as a potential conflict of interest due to my appointment as Chief Executive Officer at cohealth.

As Board Director I chaired the Primary Care and Population Health Committee and was a member of the Cultural Diversity and Community Advisory Committee.

Deputy CEO *May 2014 – September 2019*

cohealth

Responsibility

As the primary strategic partner to the Chief Executive and second most senior executive, acting as the administrative leader with responsibility for the operational execution of the Board's strategy, operational performance of the organisation and operational oversight of the Organisations Services, Corporate and Finance functions.

I worked closely with cohealth's Board to ensure cohealth's corporate governance aligned to cohealth's vision of healthy communities, healthy people. I had lead responsibility for the Board's Finance and Audit and Quality and Risk subcommittees.

Achievements

- Provided thought leadership to the CE and Board, influencing the strategic direction for the Organisation. A key feature of the new strategic direction is value based healthcare.
- Provided high level, timely and accurate advice to Board Directors as required.
- Successfully managed the Board's Finance and Audit and Quality and Risk subcommittees, improving systems for reporting and the quality of Board briefings.
- Successfully led the establishment of the Organisation's governance framework.
- Successfully led a number of large internal change programs to align organisational structures and functions to strategic direction.
- Oversight for the Organisation's culture building program which has resulted in improvement in a range of organisational culture indicators since the merger.
- Successfully built and grown key stakeholder partnerships to deliver better integrated and coordinated healthcare to the community.
- Successfully led the integration of critical business systems following the merger, including ICT, Information Management, Finance, HR, Risk and Compliance and Quality systems.
- Oversight of the Organisation's quality system, including clinical governance, and successful quality accreditation outcomes.

- Oversight of the successful development of the Organisation's Financial Plan, underpinning the Organisation's strategic direction.
- Oversight of the development of Organisation's Service and Capital Infrastructure Plan and the implementation of the plan which has resulted in improvements to 'places and spaces' for staff and consumers.
- Minor and major capital development including a new health clinic (78 Paisley Street Footscray) which was delivered through a public and private partnership under budget and on time.

Acting CEO *October 2013*
to May 2014

Western Region Health Centre (WRHC)

Responsibility

Reporting to the Board, I have overall responsibility for the leadership and management of WRHC ensuring the day to day requirements of the Organisation are met and the Board's key strategic priorities are achieved, including the merger of Western Region Health Centre with two other community health service organisations.

Achievements

- Worked with the Board to set the vision, strategy and direction of the Organisation.
- Successfully achieved the Board's strategic direction to merge the Organisation.
- Provided high level strategic advice and reporting enabling the Board to fulfil its governance responsibilities.
- Oversaw the corporate governance of the Organisation, including audit, risk and clinical governance obligations.
- Successfully provided oversight of the Organisation's $40 million budget, including overseeing financial planning and funding arrangements, preparation and delivery of budgets, provision of financial results and interpreting financial performance.
- Successfully led 350 staff to deliver safe, high quality, person-centred health and wellbeing services during a period of significant organisational change;
- Managed key strategic relationships with local politicians and other key stakeholders.
- Responded to media enquiries; positively positioning the Organisation as an advocate for social equity, a leader in the public health policy domain and a strong community voice.
- Successfully led the executive leadership team through the merger transition and all aspects of the related change process.

Board Director (non-executive) *December 2011 to 2014*

Macedon Ranges & North Western Melbourne Medicare Local

Responsibility

As a member of the Board, I was responsible for fulfilling the duties and obligations of a company director under the Corporations Act 2001, ensuring effective governance of the Macedon Ranges & North Western Melbourne Medicare Local.

Achievements

- Actively developed relationships with Board Directors and the CEO to influence Board culture.
- Played a key role in setting the vision and strategic direction of the Organisation, including the ongoing monitoring of performance against the strategic objectives.
- Chaired the Risk Management Internal Audit Committee; fulfilled obligations to ensure that there are adequate systems for governance, including the establishment of a risk management framework.
- Actively provided oversight for the governance and performance of the Organisation.
- Approved the annual budget and business plan.
- Successfully achieved a merger and subsequent creation of the Macedon Ranges North Western Melbourne Medicare Local.
- A member of the CEO recruitment panel; successfully appointed a new CEO.
- Managed the performance of the CE.
- Provided high level advice regarding the development of the Board governance charter and code of conduct.
- Participated in Board self-assessment and review processes for Board and individual development.

Deputy CEO & Company Secretary *September 2012 to January 2014*

Western Region Health Centre

Responsibility

Reporting to the CEO, I was a member of the Organisation's leadership team and played a key leadership role in shaping the organisation's corporate and strategic directions.

Achievements

- Responsibility for Corporate Governance within the Organisation; enabling the Board to make key strategic decisions within a complex policy environment and with an increasing tension between delivering community outcomes and achieving financial viability and sustainability.
- Oversight of a $37 million operation with complex income streams and funding models; successfully managed the financial capacity of the Organisation within the Board's financial framework.
- Played a central role in shaping the Organisation's corporate and strategic directions; successfully supported the CEO to implement the Board's strategic direction leading to a decision to merge.
- Strategically positioned the organisation for new business and funding opportunities, including capital redevelopment projects and new service delivery initiatives.
- Effective management of the Organisation's property portfolio (19 sites), capital planning, capital development and management of renewal schedules.
- Developed and managed complex stakeholder partnerships which have achieved positive outcomes for the Organisation and the community, including the capital redevelopment of WRHC primary site.
- Built internal capability, through system redesign to achieve a range of objectives in both the health service and corporate environment, including the redesign of service delivery models and quality, risk, compliance and infrastructure management systems. This has resulted in improved access to locally based healthcare for the community and improved performance in the corporate area.
- Successfully led and implemented several whole of organization change processes, including restructures and service redesign, resulting in improved organisational performance and community outcomes.
- Successfully implemented a change management strategy to transform the culture of the Corporate Office to one of inclusion.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT NB-2

This is the attachment marked 'NB-2' referred to in the witness statement of Nicole Bartholomeusz dated 09/06/2020.