Royal Commission into
Victoria's Mental Health System

JOINT WITNESS STATEMENT OF TASS MOUSAFERIADIS AND KENT BURGESS

I, Tass Mousaferiadis, Chair of the Board of Star Health, of 341 Coventry St, South Melbourne in the State of Victoria, make this statement with my colleague, Kent Burgess.

I, Kent Burgess, Acting Chief Executive Officer (**Acting CEO**) of Star Health, of 341 Coventry St, South Melbourne in the State of Victoria, make this statement with my colleague, Tass Mousaferiadis.

We say as follows:

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

2 We make this statement in our professional capacities on behalf of Star Health.

Background

Tass Mousaferiadis

3 In 1982, I (Tass) completed a Bachelor of Education at the University of Melbourne, followed by a Graduate Diploma in Health Education in 1985. In 1995, I completed a Graduate Certificate in Business Management at Victoria University and am a graduate of the Australian Institute of Company Directors.

4 I have a background in health and social policy, program development and strategy and have worked for State Government, statutory authorities and non-government agencies.

5 I am currently working as a non-executive director serving as Board Chair at Star Health, Eastern Health and the Victorian Responsible Gambling Foundation, and serve as a Board member of Food Bank Victoria.

6 Attached to this statement and marked "TMKB-1" is a copy of my (Tass Mousaferiadis's) curriculum vitae.

Kent Burgess

7 I (Kent) have a Bachelor of Occupational Therapy (1995) from Latrobe University and a Masters of Public Health in Health Service Management (2006) from Monash University.

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

8 I have a 15-year background in senior leadership within the community health, mental health, alcohol and drug, HIV and LGBTIQ+ health sectors. Prior to moving into leadership roles, I worked as an occupational therapist in the clinical mental health system within Victorian community clinical services.

9 I am currently the Acting CEO of Star Health. In this role I have responsibility as delegated by the Board of Directors for the operations of a diverse community health not-for-profit agency in Melbourne's inner south-east. I oversee over 350 staff across over 50 programs with an annual budget of over $35 million. I am responsible for delivering on our purpose of health and wellbeing for all. I oversee comprehensive community-based health care, which includes a large mental health and alcohol and drug program.

10 Attached to this statement and marked "TMKB-2" is a copy of my (Kent Burgess's) curriculum vitae.

Community health services

Star Health's mental health programs

11 Star Health is a registered community health provider and one of the independent, not-for-profit community health services that form part of the Victorian network of community health, which spans across the State. Star Health provides a broad range of primary care and broader health and social services across the inner south-east of Melbourne.

12 Star Health has always had a very deep and broad focus on mental health, but also delivers a range of other services, including general practice, dental services, aged care, homeless outreach, alcohol and other drugs (**AOD**) treatment services, allied health and Indigenous health.

13 Star Health offers a variety of targeted programs such as the statewide sex worker health programs, Resourcing Health & Education in the Sex Industry (**RhED**), and various health promotion programs that target population-level wellbeing. Examples of these include:

(a) our work building social connection, wellbeing and safety in the South Melbourne public housing estates through the South Melbourne Community Capacity Building Initiative; and

(b) our work with at-risk youth across the City of Stonnington via the Communities That Care partnership.

14 Community Health provides Star Health with a broad platform to provide wrap-around support to people with mental health issues. Star Health also works across the lifespan. Star Health has programs for children, youth and families (including programs that work

with children with learning and behavioural difficulties), right through to programs for older people with mental health and other issues.

15 Within that framework, Star Health has a number of funded mental health programs. Previously, Star Health was a large provider under the old Mental Health Community Support Service (**MHCSS**) system. Star Health always delivered those services with professional allied health and mental health nursing staff. That meant we had a real focus on clinical expertise, but within a psychosocial community environment. At any given time, we had about 450 people with severe mental illness in that program.

16 Currently, with the changing landscape, Star Health delivers psychosocial case management and support under the Early Intervention Psychosocial Support Response service (**EIPSR**). In this program, we work with clients of the Alfred Hospital's mental health services, providing the psychosocial programs and care co-ordination whilst Alfred Health staff provide clinical treatment and care.

17 Star Health also delivers some specific programs for the Department of Health and Human Services (**DHHS**), providing mental health in-reach and case management for people living in public housing. Through Commonwealth-funded programs, Star Health delivers the Mental Health Integrated Complex Care (**MHICC**) program, which provides nursing and care co-ordination support to people with severe mental illness who are not in the state-funded clinical mental health system. Star Health delivers the MHICC program in several local government areas through the South Eastern Melbourne Primary Health Network (**SEMPHN**) catchment area.

18 Star Health also delivers services to people on the mild and moderate ends of the mental illness spectrum through:

(a) our state-funded community health counselling care co-ordination programs; and

(b) various care co-ordination programs that target vulnerable clients, such as people over 55 in public housing, and people who are homeless.

Our various care co-ordination programs are all targeted to people with chronic and complex needs and mild and moderate mental health issues.

19 Star Health is also funded by the SEMPHN to be an Applied Psychological Interventions (**API**) Provider. As such, we provide counselling, psychology and mental health sessions to those people who can't access a general private provider under the mental health care plan program.

20 Star Health also delivers National Disability Insurance Scheme (**NDIS**) programs to people with mental health issues. Star Health's focus is on adults with psychosocial disability to whom we provide support coordination and therapeutic supports. We also

provide therapeutic support to children with learning and developmental disabilities, and their families.

21 All these programs have very tight eligibility criteria. The programs are also delivered and overseen by differently funded contractors (at both state and federal levels). The programs are all very time-limited. Moreover, if you move from one program to another, you have a completely different service provider and a completely different stream of services that can be provided. For example, to access the EIPSR program with our Alfred Hospital partner, you need to be a clinical receiver of a clinical mental health service from The Alfred. If you're not, you need to go to the PHN MHICC program, or go to a provider other than Star Health and get the National Psychosocial Support Measure (**NPS-M**). In the post-MHCSS environment, there is a great fragmentation of the system.

22 Prior to the defunding of MHCSS, Star Health could provide psychosocial rehabilitation, support and case management to a person will mental illness and their family through their illness and recovery journey. Care was not time limited but led by need, and could be scaled up and down in intensity as the person's needs changed without needing to move the client to a different agency or service type. This gave the person and their family consistency, trust and professionals who knew them through all stages of illness and wellness. Due to the way the system is currently structured, Star Health can no longer provide consistent support and case management throughout a person's recovery journey.

Distinguishing factors between community-based settings and hospital settings

23 Quite clearly, acute episodes are best treated in hospital environments. Often, they require a bed-based service and specialist psychiatric care. We are not familiar with any models operating successfully in Australia where acute illnesses are effectively delivered in community-based settings, but that might be something that is worth exploring. Our view would be that everything other than psychiatric care for acute illness could be effectively delivered in a community-based environment. In fact, if you look at the way in which our current model of care has been developed, public health services that operate inpatient services also operate community-based clinics. Sometimes those clinics are linked to other community-based services, and sometimes they're not. In our case, at Star Health, we work very closely with Alfred Health and its community-based services. We often try to work much more collaboratively and wrap services around the consumer, which is the right model.

24 It is critical that clinical and psychosocial care are truly integrated so that the client and family receive coordinated care where everyone knows them, each other and their single integrated care plan, rather than silos of care that fragment and duplicate. Such silos

create complexity and risk; someone who is unwell often will not be able to navigate a complex, disjointed system.

25 What we need is a system that is *oriented to the community*, which is where the person is situated. We would like to emphasise to the Commission that the important things in the mental health system are continuity of care, and having a system that guides and supports people to navigate it. These are important, no matter the stage of life or stage of illness, whether you're young or old, or mild, moderate or severe in your mental health issue. The model of care that is needed is one that is focused on continuity of care within the community, and on access to either sub-acute or acute hospital-based services.

26 There is a role for acute hospital beds, and also for more innovative sub-acute models in the community, that are more home-like. There are some innovative examples of that, both within the Trieste Model of northern Italy, and within some peer partner models such as the Fusion Model in the US. The important feature is that the care team is community based.

27 The ideal scenario is that the core care team for an individual person (for instance, their psychiatrist, multidisciplinary health team, and care co-ordinator), should stay the same regardless of whether the individual is in the community, or in the acute or the sub-acute settings. While there is a team of nursing, and psychiatric staff who can support that person within the acute setting, their care team should see them right through that journey. The community-based care team retains duty and continuity of care supported by the acute inpatient treating staff who need to be onsite. To place care of someone at their most unwell with clinicians who do not know the person, their clinical presentation and wishes when they are more well, does not create a care environment where the person's needs and wishes can be best understood.

Integration of services and care coordination

28 Community health provides a setting that works with people across the lifespan and also across the course of mental health issues. Star Health is an expert in health promotion and in working at a population level. We work with early intervention. For example, as mentioned above, we work with people with mild to moderate illness through community health funded counselling models. But we have also been working in the severe mental illness space for the 40 years of our existence. If you want an integrated system, then you don't split off the psychosocial aspects from the clinical aspects. These are all part of a multidisciplinary team that can be delivered from a community model in partnership with hospital-based services.

29 Ideally, community health is a destigmatised environment that addresses *all* health needs, not just mental health. An integrated community mental health centre service

model would deliver care from psychiatrists, allied health staff, psychosocial group programs and interventions, peer navigation and peer support, and right up to and including sub-acute bed-based services and physical and primary care. These community mental health centres can be delivered with community health as the lead, in partnership with the local hospital network and other providers.

30 We really need to be thinking holistically. We need to think about all the other services that a person with mental health issues may need, beyond their mental health direct team, such as social services, AOD services, family violence services and vocational services. Many of those services are already provided within community health organisations like Star Health, or we can provide the care co-ordination that links in those services with our key service partners that do deliver them. We need to think very broadly about all of these other services when delivering or co-ordinating care for people with mental health issues.

31 Community health is an excellent platform with infrastructure in every municipality across the State of Victoria for the delivery of care co-ordination. The platform already exists; however, it is not consistent and could be built on in a very exciting way going forward. Many community health services already have the expertise to deliver mental health care. Those community health services with less past experience in delivering mental health services have expressed interest in partnering with other providers to build capacity. These other providers may be other community health providers or other mental health service providers already imbedded within a geographical area.

Responding to diversity

Working *with* our communities

32 Our view is that all sub-population groups (such as LGBTIQ+ people, culturally and linguistically diverse (**CALD**) people, women and young people) require a nuanced service. For a service to be truly inclusive for all those sub-population groups, and able to deal with a diverse range of needs, it needs to be able to reflect the communities that it is actually working with.

33 One of the themes that often comes to mind is: working *with* our communities, rather than working *for* our communities or working *to* our communities. That means really understanding what the needs of diverse population groups are and being able to build that understanding into our policies, practice and the way we design our service and our service models. In our view, community health does this very well. Our health services are doing this better. Centrally driven policy requirements have very much encouraged health services to develop policies and programs, and to do some intense planning around how they actually deliver services to diverse populations.

Factors that assist a service to be responsive to diversity

(a) Targeting sub-populations

34 To acquire the knowledge of what your community needs, you have to understand who your community is. There are many ways you can do that, such as looking at simple demographic data, holding focus groups, doing consultations or holding community advisory forums. There is a whole range of tools and mechanisms that you can use to tap into and understand what your community thinks.

35 For example, I (Tass) have elderly parents of a Greek-speaking background who don't speak a lot of English anymore. In relation to accessing health care, their preference now is to choose carers who are bi-lingual and bi-cultural. That way, they don't have to have interpreters who are part of the equation, or need to drag their kids along to act as an intermediary. It empowers my parents to engage with their carers on a basis that they understand. I think the same principle applies for LGBTIQ+ people, or for young people, or for women.

36 Another sub-population group is men. Men also have particular, nuanced needs. Sometimes the needs of males have been missed in the discussion of sub-population groups. But men do need to be considered, because they engage with services in a very different way to other population groups. Of course, there are men who can be part of other sub-population groups (such as gay males or males from non-English speaking backgrounds). But there is a good body of research showing that men as a whole need tailored approaches as well.[1]

(b) A community-led model

37 The foundation of community health is about a given geographic community developing the health services it needs *from within*. It is a community-led model. Therefore, at Star Health we are guided by a community and consumer participation framework that ensures we have all of those mechanisms in place to co-design. We cannot assume that we are experts within each of the many diverse or intersectional populations we serve. It is about engaging them in every stage of the process, across development, implementation, delivery and evaluation.

(c) Reflecting our diverse community and partnering with local organisations

38 At Star Health, our target cohorts need to be reflected in our workforce, in our physical environments and in our messaging. Those cohorts need to have a voice in everything

[1] See, for example, Beyond Blue's research into men's help-seeking behaviour: Hall & Partners Open Mind, *Men's Help Seeking Behaviour: Report of Research Findings* (14 September 2012) <https://www.beyondblue.org.au/about-us/research-projects>.

that we do. We also need to partner with lived experience organisations that reflect those communities.

39 For example, LGBTIQ+ is a big target cohort for Star Health, so we partner with LGBTIQ+ led organisations like Thorne Harbour Health. To include the voice of CALD communities, we partner with specific cultural community groups within our catchment area. Forming partnerships with specialist, diverse organisations is absolutely critical.

(d) Safe and welcoming spaces

40 For example, a number of our Aboriginal consumers say to us that each time they turn up to our health service and see an Aboriginal flag on display, it immediately makes them feel comfortable to know that we acknowledge who they are and where they're coming from. Things like flags are simple symbols that you can have on display—but you need to earn the right to be able to display those. For example, we have done a lot of work to ensure that we have rainbow accreditation. That allows us to then have the rainbow tick on display, and therefore send a very clear message to our LGBTIQ+ consumers that we are welcoming and open to them coming forward.

Factors that hinder a service from being responsive to diversity

Lack of funding and resources

41 Something that hinders a service is the lack of funding for the time that it takes to work with someone through their intersectional and diverse needs. At Star Health, we use a very holistic, comprehensive assessment framework that looks at the whole-of-life needs, regardless of whether someone is coming in for a specific mental health issue. That work is absolutely required, but it needs time and it needs to be supported by resourcing of secondary consultation from people who are specialists in that particular cohort. Whether you're working with someone from a CALD background or an LGBTIQ+ background, or someone who has a co-morbidity such as AOD issues or physical disability, you need to be able to do that secondary consultation with people who have specialist skills in that area. That takes more time and it takes more resources.

42 The availability of interpreters is another very practical issue that limits how responsive a service can be to diversity. Responding diversity also means being able to make "reasonable adjustments" and this means more resources are required to adapt responses and provide increased time to meet intersectional needs.

Cultural and linguistic diversity

Overcoming the stigma about mental health

43 To overcome stigma, it is critical that we work in partnership with our diverse communities, whether those are CALD communities or other communities.

44 There is a dual role here for Star Health. As a health provider we are able to gain the specialist knowledge of that cultural cohort in partnership with those communities and the local community groups. As a community health promotion agency sometimes there is also a role for us to help address the stigma that may exist in particular communities around mental illness. We can help address stigma around some of those other intersectional issues in diverse communities, whether it's physical or intellectual disability, LGBTIQ+ identities or something else.

45 We have a responsibility to help address stigma within those diverse communities in a sensitive way, in partnership with them. We can only do that by forming partnerships with representative community groups, organisations and community health.

46 Star Health is a platform that offers many types of services—not just mental health, and not just for a particular cohort. This means that it's a non-stigmatised environment that allows us to do that work of addressing stigma.

47 Professor Anthony Jorm from the University of Melbourne has done quite a lot of work in this space.[2] His work unpacks different types of stigma—whether you look at personal stigma, self-stigma or institutionalised stigma. But more importantly, his work shows there are not very many examples of population-based approaches to tackling stigma, and that the best approaches are very much personal-contact approaches.

48 A practical example of the personalised approach is Star Health's volunteer concierge program. Star Health is not funded for peer navigators, but we have a very successful program of volunteer concierges at our sites. The program involves people with lived experience who are our consumers and who we have trained in consumer leadership and in engagement. These volunteer concierges guide people into our service and welcome them. The volunteer concierges often represent our intersectional client groups, and they use their own lived experience within that context. We have found the volunteer concierge

[2] See, eg, Amy J Morgan et al, "Interventions to Reduce Stigma towards People with Severe Mental Illness: Systematic Review and Meta-analysis" (2018) 103 *Journal of Psychiatric Research* 120; Nicola J Reavley and Anthony F Jorm, "Experiences of Discrimination and Positive Treatment in People with Mental Health Problems: Findings from an Australian National Survey" (2015) 49 *Australian and New Zealand Journal of Psychiatry* 906; Anna M Ross et al, "A Systematic Review of the Impact of Media Reports of Severe Mental Illness on Stigma and Discrimination, and Interventions That Aim to Mitigate Any Adverse Impact" (2019) 54 *Social Psychiatry and Psychiatric Epidemiology* 11.

program to be incredibly successful, and it is also a pathway of empowerment and training for each volunteer.

The relationship between culture, stigma and language

49 In the past, I (Tass) have worked with ethnic communities, and I have found it interesting to observe that different cultural groups have different language to describe different conditions. For example, my (Tass's) elderly parents don't have a word for "mental illness" other than to describe it as having "a rotting brain". That kind of language is highly stigmatising, and it is very difficult for non-specialist services to deal with that. In relation to some of the newer communities and groups, we can only imagine what their language nuances and needs might be.

50 Ensuring that diverse communities have access to services is not just about delivering services in another language; it's about being culturally appropriate, and then being able to turn what is being said into language that is factual and non-stigmatising, and that actually deals with the presenting issues.

The role of culturally specific and other specialist services in a community-based mental health system

51 A model of having a single centre or place where all services are co-ordinated allows you to partner to meet the needs of *your* community. You could imagine a mental health centre within a community health led environment where there is in-reach or co-location with the particular culturally specific or other specialist services that are relevant to your community.

52 For example, as we noted above, Star Health has partnerships with Thorne Harbour Health as the LGBTIQ+ led health service. We have workers from their service working within Star Health's centres to provide a specialist peer-to-peer LGBTIQ+ service. This is an example of a two-way partnership through a formal arrangement. We have an arrangement in the AOD treatment space with Thorne Harbour Health, which has trained our AOD intake team how to be LGBTIQ+ sensitive. We run for Thorne Harbour Health an LGBTIQ+ AOD referral line, and we also provided them with specialist training in AOD service provision. There is mutual training and development. There is also the availability of secondary consultation in both directions. When a diverse community provider is working with an individual with a mental health issue, then the local community mental health service needs to be able to provide that secondary and primary consultation opportunity for that particular individual.

53 The same kind of partnership model could be done for whichever cohort is important for the particular local catchment area.

54 It is about having the ability to do a screen of every client and assess their broad comprehensive needs, and then call in secondary consultation or, if necessary, primary consultation from a specialist provider. A specialist provider is not going to be able to meet the needs of every client en masse, but they are there for education, training, secondary consultation and then, when needed, primary consultation to work with you with that client.

Facilitating access to services beyond mental health services

55 Sometimes consumers require other services instead of, or in addition to, community-based mental health services. Within Star Health's mental health services, there are partnerships with vocational training and support providers. We have particular portfolios within the mental health team where the staff have knowledge of those pre-vocational pathways. We also have a pre-vocational group program for our mental health participants around areas like work readiness, routine, self-esteem and skills development. Then we work in partnership with vocational providers, which includes in-reach by them into our service, where they come and we have joint assessment sessions and information sessions for participants. The model at Star Health acknowledges that even though community health is comprehensive, it is not everything. Working in partnership is not just about each organisation agreeing to take referrals from the other. It is about formal partnership agreements, in-reach, and shared locations for those service models that bring the vocational and training provision into the service model.

56 Star Health had made this partnership model operate for some of our consumers, but it is not a universally available model. We do our very best to help our consumers navigate across services and across different needs, but we are not necessarily funded to do that. In fact, there has been a recent diminution of the resourcing and support that has allowed Star Health to do that partnership work with the broader social system. The new funding arrangements are now forcing us to question how we deliver that work. Having strong partnership is a priority for us, but in the reality of having to deliver a balanced budget at the end of the year, it makes it much more difficult for us to provide the broader social health services that are going to make the difference in keeping a person well in the community and out of acute services.

Fragmentation of current helpline services

57 A significant limitation of our current helpline services is that they are highly fragmented. This is a real problem area. Knowing who to call is very, very confusing. For example, our clients have reported a lot of confusion around what Beyond Blue's line offers that differentiates it from what Lifeline's line offers.

58 The telephone services are even more fragmented and difficult to access if you are a person from a CALD background, and even more so again if you have more nuanced needs above that. If you are a person who doesn't speak English well, then what do you do? Who do you go to?

59 Within my (Tass's) lifetime, the DHHS has attempted three reviews of its helplines. It has tried to reduce them to a handful of lines that deal with broader groupings, but those efforts have not succeeded, because of course every single disease group or advocacy group believes their line is highly specialised and necessary.

60 There must be a better way of structuring these services, in which consumers can have visibility to get into a single point of contact, and then be referred or patched out into more specialist services. We favour a model similar to the triple-zero service, where you can call that single number and you are then patched off to the right service, and at the same time they can identify what your linguistic needs are and pull that support in as well.

61 An example of a helpline service done well is through Turning Point, which operates dozens of different telephone help services. Some of those services are for AOD, some are for gambling help; they cover a whole range of other specialist, nuanced areas.

Governance and commissioning

The fragmented model of commissioning

62 In the current, fragmented system, different services are funded by different governments and different government agencies, and have different reporting and accountability requirements. All of that compounds the level of work that Star Health and other services are required to do. We are required to collect as much data as we can to furnish the different reporting and accountability requirements across different agencies. We have contracts with a number of government departments and agencies both at the state and federal levels. Those contracts are all very, very different and all very complicated. The administrative burden is significant.

63 Star Health's organisational viability, in terms of governance and finance, has been impacted by the fragmentation and contract-management obligations. Importantly, the model of commissioning also impacts on quality. The price per unit of service delivery has been significantly reduced through the changes in the system since the dissolution of MHCSS and the old Personal Helpers and Mentors Service (**PHaMs**) programs.

64 The current mechanisms for funding have driven down the unit price through competitive tendering. These mechanisms have fragmented the services and created silos. This means that service providers are often helicoptered into a geographical area instead of building a geographical service system that is integrated.

65 There are many service providers that are highly competitive. Some people would argue that some competition is useful, but in fact the rise in competition has fragmented our health service system, and especially our community-based service system. We should be looking for much more collaborative approaches.

66 By funding a whole lot of disparate little service models, for which only narrow groups are eligible, we end up spending more money on the system, and clients get pushed from service to service. Instead, we could fund a geographical, integrated system, where everyone through the governance mechanism is required to work in an integrated model. This would create greater efficiencies, both financially and in terms of person-centred care.

Continuity of care and a navigable system

67 Integration of services and care co-ordination are critical. In my (Tass's) experience, both as a professional manager and also as somebody who has supported people with mental illness in the community in my own network, our service system is far from being person-centred and far from actually being able to co-ordinate itself. In our view, that is very much a missing link. People with more serious mental illness and enduring disabilities are often left on their own to find their own way and navigate health and community services, rather than the service system wrapping itself around the consumers and there being a point of reference from which they can co-ordinate the care across all their needs.

68 To achieve continuity of care and a navigable system, there needs to be a central point that does not change as a consumer's needs and services change within the system. There needs to be an agency or service model that provides the consumer with continuity of care to navigate and co-ordinate that system. The capacity to achieve that has been massively reduced with the reforms to the system (when MHCCS and the old PhaMs programs were dissolved). The NDIS does not provide that central point. There is no governance mechanism to ensure integrated care or to allow that care co-ordination model which is so critical.

An integrated and consumer-focused approach to governance

69 In our view, we need to approach governance by thinking about the governance around our consumers and how we package services and support around the consumer. Governance for us is not just about the management of the services, but about the governance of services around the consumer themselves. What we need is a strong care co-ordination function and a multidisciplinary approach. For example, the multidisciplinary team might be responsible for making decisions around the care needs of the consumer (obviously with the consumer's consent) and the care navigators or co-ordinators might

be responsible for implementing those decisions in partnership with the consumer, and for working with the consumer across the service system.

70 At Star Health, our focus has been very much on thinking about the governance around our services and our agencies. We should instead be thinking about an integrated approach more broadly across the local system. Ultimately, who ends up being the governing agency is less important than the integration of those services. That has to be the focus of our approach to governance. The decision about which mechanism we use to bring that together is something that needs further thought.

71 In saying all of that, there is no question that there will end up being a richer service response, a richer consumer experience and greater efficiencies if services across agencies delivered to the consumer are integrated. For example, there will be lower overheads, and less management. Ultimately it will be possible to cross-subsidise to some degree.

72 Because of the way in which most funding models currently operate, that is activity based, it is now very difficult to cross-subsidise services. We are funded to deliver particular services, and it is difficult to take money away from one service and put it somewhere else. Bringing services together means it is possible to deliver a range of services at a lower overhead cost than if they were split apart.

What integrated governance could look like

73 As noted above, we should approach the question of governance from a client-based perspective. A person in the community should be able to come into some sort of community mental health service where the different parts of the system are integrated. The funding for that person is held in partnership between the client, their carers and that community mental health service. The community mental health service then provides care co-ordination, based on the needs of that person at any given time. The care co-ordination sees the person through the system, regardless of whether that person is there for early intervention, or for mild to moderate to severe mental illness.

74 The care co-ordination model can be light touch, or it can be intensive. Under the intensive model, the co-ordination would ramp up and down, and buy in the services that the person needs at any given time. Those services could be purchased from within the community health centre environment (for example, for a psychosocial living skills program), or those services could be purchased from partnerships with, for example, acute inpatient services.

75 The governance sits with the client and their care team. The care team is always within that one service, and is not passed on. The care team and the care co-ordinator remain

the same, regardless of the person's needs changing over time or the parts of the system that they are accessing at the time. This model brings continuity of care, a focus on the community as the centre of the work, and face-to-face case management or care co-ordination.

The use of a package of care, and the limitations of an NDIS-style funding model for mental health

76 Under the NDIS funding model, funds are attached to the consumer, and the consumer chooses how they are allocated. The NDIS funding model is not the *only* way to deliver integrated care, but there is something attractive about funds being available for allocation by consumers or by their carers, navigators or co-ordinators.

77 In our view, it is not appropriate in the mental health space to adopt a full insurance model that gives control of the funds to the individual. Funding needs to sit with the service as a package of care, similarly to how a My Aged Care service provider will sit with an agency. Clients should not have a choice to be able to go to 100 different providers, as they do under the NDIS. Instead, within a geographical area, there should be a community mental health service, and for each person there should be a package of care that they are eligible for at their phase of life and illness, and that package of care should be managed between the care co-ordinator, the client and the family. The money should sit with and be held within that community mental health service, within that partnership and that team. This funding mechanism would avoid pushing down service quality or creating a competitive environment; it would instead support a system of care.

78 We have heard from numerous informal sources and some unions that the NDIS's funding model has had negative impacts on the workforce. The workforce is disenfranchised, and has become highly casualised.

79 For these reasons, as well as the fragmentation that has resulted from a rise in competition between service providers, we would caution against going down the pathway of an NDIS model. It is important that the governance around the consumer is also the governance around the funds. In this way, funds are really managed around the consumer's needs. Under the NDIS, there are allocated funds with funding caps. That can be problematic, because it means that decisions are made about the services that the consumer receives. This means that care co-ordination often remains unfunded. That funding model would be counterproductive in the community mental health space as well.

80 We could learn from funding models for primary care that exist in New Zealand and the UK. In these models, a consumer gets attached to the local service, and then the package is delivered by the local service in partnership with the consumer, based on their location. This funding model means the system is consistent and not fragmented.

The use of governance arrangements to empower community health services to deliver improved outcomes for consumers, families and carers

Integrating the governance arrangements of mental health services and broader health services

81 I (Tass) have some experience on public health service boards. This experience informs my opinions on the merits and limitations of integrating the governance arrangements of mental health services with those of broader health services. In my view, it would be counterproductive to split out mental health services from general health services at this point in time. Victoria has gone to a lot of trouble to integrate general health and mental health services. While some aspects are not working particularly well, others are.

82 For example, in my view, the model of having emergency departments as the entry point into the acute system has not been very successful. We are seeing a lot of very disruptive behaviours in emergency departments, where lots of vulnerable people come with very diverse needs and issues.

83 In my view, a better example is the model that operates at Eastern Health out at Maroondah Hospital. They have a Psychiatric Assessment and Planning Unit (**PAPU**) that operates next door to the emergency department. The emergency department has capacity to feed in and across to the PAPU as required. If the emergency department receives a psychiatrically acute unwell patient who also has other health needs, the hospital can deal with those needs in an integrated way.

84 Star Health wishes to emphasise the importance of bringing community health providers into the fold in terms of shared collaborative governance, rather than taking anything away from the hospital mental health providers. We also need to avoid creating a situation where the community mental health provider is a poor cousin, who is commissioned by the hospital to provide a certain service. The governance and consortia arrangements need to give equity to the different partners. In this way, the focus can be on *community* and on the location of the person's environment, rather than their needs being trumped by the acute system. We need an integrated approach which also gives us integrated governance.

Workforce considerations

The attributes, skills and capabilities of a workforce that helps people from diverse backgrounds to navigate the system

85 For a service to be responsive to diversity, its workforce needs to have a balance between skilled mental health clinicians, psychosocial providers and people with lived experience.

All of those people can reflect the communities they serve. For example, the workforce should reflect the diversity of those communities in terms of LGBTIQ+ or other diversities.

86 Often a person with lived experience is excellent in the role of supporting someone to navigate the mental health system. However, if a clinical psychiatric assessment is needed, you will want to do that with the input of clinical mental health professionals, psychiatrists and allied health. These are different skill sets. For example, there are care co-ordination skills, which require a greater level of assessment skills. Then there is a psychiatric clinical assessment, which requires a psychiatrist or a skilled mental health professional.

87 Within the framework, you need to start with a broad, comprehensive, common assessment that can help identify an individual's specific needs. The assessment needs to consider the person in a holistic way, identifying their diverse and intersectional needs. Once you have started with a common, broad assessment, you can then prioritise and bring in the appropriate services and support to meet the very particular needs of that individual.

The role of the lived experience workforce in making a service responsive to diversity

88 Organisations need to get a lot better at supporting and training the lived experience workforce. People with lived experience are certainly adding value, and we need to have that diversity of lived experience to encourage access and appropriate engagement. The question is how do we best support and train those people? We need to make sure we are not setting them up to fail by putting them in roles without sufficient support and training. There are people who have trained for four to six years at university to do this work as mental health professionals such as psychiatrists, nurses and allied health staff; we should not be giving that same work to the lived experience workforce without providing them with adequate training and support in those roles.

Tapping into the diversity capability of the broader workforce

89 The workforce already has skills, attributes and characteristics that are probably not being utilised as effectively as they could be. As long as it is done as an invitation and with sensitivity across the board, and as long as you do not out anyone or assume anyone's intersectional identities, then there is real scope for people using their experiences in their work. At Star Health, we are attempting to tap into the existing diversity capability of our workforce. For example, we run an LGBTIQ+ AOD helpline, and we give members of our workforce who identify as LGBTIQ+ the opportunity to staff that hotline.

90 When we run specialist group programs for specific communities, we always make sure that at least one of the facilitators is a peer facilitator from that community. For example, beyond the mental health space, Star Health works on the health and wellbeing of sex workers. In that work, at least one facilitator of any group program is always someone with lived experience of sex work. We apply the same approach in mental health, or when we work with someone with mental illness from a CALD background.

91 Star Health is known for being an organisation that celebrates people's individual identities, particularly around sexuality, gender identity and people's intersectional disabilities. In our experience, staff absolutely relish the opportunity to draw on their own experiences at work. If you are a workplace that celebrates people's identity, then that becomes a really positive cultural value-add in your workforce. If you allow a person to be their authentic self and you celebrate and accept that (whether it is lived experience of mental health issues, or queer identity) then that person becomes more engaged, you get more out of them, and they do better, more authentic work with the consumers.

Quality and safety

Star Health's internal quality and safety arrangements

92 Star Health has a quality and safety framework within the organisation that sits within our quality and safety policy. The policy ensures that we meet all the legislative requirements, and particularly the funding requirements.

93 At Star Health, our quality and safety system is about continuous quality improvement. We have a quality manager, a committee of the Board for clinical governance, and a quality and safety committee. There is an internal reporting framework that goes up to the Board, which measures us against all the clinical governance and safety standards for both workforce and clients. The framework covers incidents and complaints and all of the various other elements that make up a quality framework. We accredit every three years against the standards.

The administrative burden of over-accreditation

94 Star Health is required to be quality accredited in all areas of our service. We are a comprehensive organisation, and as such we are currently required to report against seven sets of standards. That is, there are seven different sets of standards that we are accredited against. Each of the standards has a different focus, but there is a large amount of overlap between them. The administrative burden of reporting against seven sets of standards is absolutely enormous. It means that we have to focus too much on auditing success instead of continuous quality improvement.

95 Community health is one of the most over-accredited and over-assessed sectors in the system. When we do our quarterly reporting to, for example, the PHN, we are required to report on quality and safety parameters. We do not object to reporting on quality and safety, and acknowledge our quality and safety frameworks are critical. However, the lack of alignment and co-ordination of the accreditation standards is a great challenge, because we are not resourced to do the level of monitoring and reporting that we need to do. Our safety and quality system has been over-governed by the seven sets of standards.

Creating a culture of quality and safety

96 In relation to quality and safety, there is the accreditation piece, but there is also the cultural piece. Both are important. For our quality and safety systems to work, there has to be a culture of trust within the organisation, and in the way in which information is reported to the Board and the Board committees. We have a great culture at Star Health. Reporting is very honest and forthcoming. You need to proactively create that culture, otherwise you do not know what is going on and people are not going to own up to mistakes and choose to learn from those mistakes.

97 Star Health has put a lot of effort into creating a culture of quality and safety. For example, when we have not had the skills, capabilities or specialist expertise on our Board to oversee quality and safety, we purchased that in. That has been useful and helpful, and our arrangements work well at the moment. However, as we have said, none of this is funded work, so it comes at a price.

The work of streamlining the standards and regulations

98 The regulation of quality and safety needs to be streamlined and integrated into a consistent and centralised set of regulations. Someone needs to do the work of mapping all the different sets of standards together, so that compliance can be in one space for all of the central elements, with just the specialist component separate.

99 This is what the Australian Commission on Safety and Quality in Health Care (**ACSQHC**) was supposed to do, but has not done, as yet. In our experience, unfortunately the result of the work of the ACSQHC has been the opposite: they are creating yet another set of standards called the National Safety and Quality Health Service (**NSQHS**) Standards, which we now have to comply with. And we are soon to have a set of standards for primary healthcare providers, the National Safety and Quality Primary Health Care (**NSQPHC**) Standards. The ACSQHC does amazing work, but so far its existence has resulted in an increase of two further sets of standards and a lot more work, rather than any reduction.

100 The introduction of these two new sets of standards has massive implications for providers in the community health system. Not only do you have to comply, but all of a

sudden you have to transition from an old set of standards to a new set of standards, with new sets of reporting requirements and new sets of arrangements. The implication is that health services should be able to comply with accreditation requirements within their existing funding envelopes; these accreditation requirements place further pressure on health services.

Digital and innovation

101 The COVID-19 experience is teaching us a lot about the impact of digital technologies on diverse communities' access to and use of mental health services. We are learning a lot about how much can be done digitally. At Star Health, we are doing as much of our work remotely with consumers as possible, and people (both staff and consumers) are being challenged to move into that space. The pandemic has created rapid change and is helping overcome resistance to connecting in digital spaces with clients. We are learning the benefits and limitations of working digitally but we have only begun to scratch the surface of the potential.

102 For example, we are seeing that video conferencing can be very effective. However, we don't have video conferencing interpreters available now. Interpreters either come out face-to-face (and we're not funded for that), or we do phone interpreting, which is cheaper (although again, we're not funded for it). Phone interpreting is fine, but it is not suitable for every situation. For example, phone interpreting is less than ideal when you are trying to do a very subtle mental health assessment. Video conferencing with interpreters would allow a little bit more of the nuanced mental health assessment to occur. There is an opportunity there, given the limited resources available for interpreting services.

Impact of COVID-19

Emerging changes in mental health service delivery as a consequence of COVID-19

103 Star Health's mental health services have been quick to adapt to a focus on remote support via online and telephone methods supported by face-to-face methods as necessary. Whilst this has been very positive and consumers and families have appreciated the regular contact, it has not replaced the need for face-to-face contact with consumers. As the pandemic continues into months, it is more evident that for many consumers with serious mental illness more face-to-face contact is becoming necessary. These consumers may not have the coping skills to adapt as successfully as other members of the community, and we are seeing significant deterioration in many people's mental states. We are increasingly needing to send staff out to see clients.

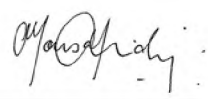
104 There has been an emphasis on increased resourcing and access to national telephone support services. This is necessary; however, it does not provide sustainable support that

connects people to their local service system, supports and community. There has been a lack of focus on supporting the existing local community mental health supports to respond to increasing need to connect with existing clients. There has also been a lack of focus on the need to connect into local supports new people who are slipping into mental ill health during this time.

Opportunities to use digital technologies in the longer term

105 The greater utilisation of digital technologies in mental health support has been a positive outcome of the pandemic. The pandemic has accelerated uptake of these technologies by staff, consumers and their families. However, there is a great risk that these tools are used in the future as cost-cutting alternatives to face-to-face care rather than valuable adjuncts.

106 The role of online clinical review, psychosocial support, therapeutic interventions (both individual and group) is extremely valuable. It will take more time for staff and consumers to feel comfortable with the expanding potential of these modalities. The expansion of their use will need to be based upon what consumers and families are comfortable with. Again, they will not replace the need for localised face-to-face mental health services.

sign here ►  *sign here* ► 

print name Tass Mousaferiadis *print name* Kent Burgess

date 20 May 2020 *date* 20 May 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT TMKB-1

This is the attachment marked "TMKB-1" referred to in the joint witness statement of Tass Mousaferiadis and Kent Burgess dated 20 May 2020.

Tass Mousaferiadis GAICD

Postal address PO Box 103, South Melbourne 3205

Tass has an extensive background in social policy, program development, strategy, communications and governance with the Victorian Government and the health and community sectors. He has worked in leadership roles across a range of public health policy and program areas with the public service and numerous non-government organisations.

He currently consults to health and community organisations on public health policy, strategy, development and governance, and is an experienced Board chair and director serving on numerous public sector and community Boards, advisory committees and review panels.

Key capabilities

- Public health, mental health, men's health, and health services
- Research, planning and strategy
- Public policy analysis and development
- Governance
- Stakeholder relationship development and management
- Strategic communications
- Resources and program management.

Employment History

- Consultant and various non-executive and advisory roles, 2015 -
- Program Leader, *beyondblue:* men's health, suicide prevention and population health programs, 2012 - 2015
- Chief of Staff, Office of the Minister for Children and Early Childhood Development and Women's Affairs, Victorian State Government, 2008 - 2010
- Director, Research, Strategy and Policy, VicHealth (Victorian Health Promotion Foundation), 2007 - 2008
- Director, Governance and Corporate Services, Growth Areas Authority, 2005 - 2007
- Health Policy Adviser, Office of the Minister for Health, Victorian State Government, 1999 - 2005
- Various senior health policy, planning, program and management roles in the Victorian Department of Health and Human Services, 1986 - 1999
- Teaching, Victorian Department of Education, 1983 - 1985

Governance

Current

- Victorian Responsible Gambling Foundation, Board Chair, 2020, Chair Lived Experience Advisory Committee, (Board Director since 2017) member Research Policy and Advocacy, Finance and Audit, and Remuneration Committees.
- Eastern Health, Board Chair, 2019, Chair Remuneration Committee, member Quality and Safety, Risk and Audit, Consumer Advisory and Finance Committees, (Board Director since 2015).
- Council of Victorian Health Service Board Chairs, July 2019 -
- Star Health, Board Chair, 2019, Chair Executive Performance and Development Committee, (Board Director since 2012, member of Quality and Executive Committees).
- FoodBank Victoria, Board Director, Nominations and Governance Committee, Chair Strategic Communications Committee 2016 -

Previous

- Australian Mens Shed Association, Board Director, 2016 - 2019
- Parenting Research Centre, Board Chair, Chair Remuneration and Governance Committees, 2011 - 2018
- Western Health, Board Director, Audit and Risk, and Quality Committees, 2007 – 2008,
- Anex Australia Inc (now known as The Pennington Institute), Board Director, 2007 - 2008
- Western Region Alcohol and Drug Service (WESTADD), Board Director, 1989 - 1991.

Appointments

Current

- Australian Red Cross Blood Service, Blood Donor Deferral Expert Advisory Committee, 2017, and 2010 - 2012, Communications Advisory Committee, 2013 – 2014
- Hepatitis Australia, Test Cure Live Campaign Consultants Group, 2018

Previous

- Movember Foundation, Social Innovation Challenge, (Global men's mental health and social connectedness initiative) Chair Global Steering Committee and Selection Panel, 2016 – 2017, Tru NTH, (national prostate cancer collaborative), Inaugural Advisory Committee, 2012 - 2015
- University of Melbourne, Ten to Men, (National men's health longitudinal study), Chair Community Reference Group, 2013 - 2017, and adviser to the Man Up (ABC TV documentary) project, 2015-16
- Dental Health Services Victoria, Research Advisory Committee, 2007 - 2008
- University of Melbourne, Honorary lecturer, School of Population Health, Faculty of Medicine, Dentistry and Health Sciences, 2008 – 2010, and Advisory Committee, School of Population Health, 2007 - 2008
- Department of Human Services, HIV Prevention Advisory Committee, 2007 - 2008
- Australian Department of Health, Community Services and Health Australia, Industry Training Advisory Board, 1996 - 1997
- World Health Organisation, International Advisory Committee on Sexually Transmitted Diseases, 1990.

Community experience

Current

- JOY 94.9, LGBTI community radio, current affairs presenter, 2015 -

Previous

- Victorian Pride Centre, Co-Chair Communications Working Group, 2017 - 2019
- Youth Affairs Council Victoria, Healthy Equal Young People (HEY) Grants program, Assessment Panel, 2012-2017
- City of Port Phillip, Community Grants Program Advisory Committee, 2011-2012
- Switchboard (LGBTI telephone counselling, information and referral service), volunteer 2010 – 2012 and Committee of Management member 2012
- City of Port Phillip, Community Plan, Joint Steering Committee, 2006 - 2007

Education

- Finance for Directors Course, Australian Institute of Company Directors 2018
- Company Directors Course, Australian Institute of Company Directors 2017
- Diploma in Leadership and Management, Australian Institute of Management 2014
- Graduate Certificate in Business Management, Victoria University 1995
- Graduate Diploma in Health Education, University of Melbourne 1985
- Bachelor of Education, University of Melbourne 1982
- Numerous other governance and management training programs and short courses.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT TMKB-2

This is the attachment marked "TMKB-2" referred to in the joint witness statement of Tass Mousaferiadis and Kent Burgess dated 20 May 2020.

PERSONAL DETAILS

Name: **Kent Burgess**
Postal Address: P.O. Box 103, South Melbourne 3205
Email: kburgess@starhealth.org.au

EDUCATION

Masters of Public Health – Health Services Management
2006 Monash University

Bachelor of Occupational Therapy
1995 Latrobe University

Cert IV in Assessment & Training
2012 Australian Institute of Management

PROFESSIONAL MEMBERSHIPS

- Associate Fellow of the Australasian College of Health Service Management
- Registered Occupational Therapist
- Board Member, Victorian Alcohol and Drug Association
- Australian Commission on Safety & Quality in HealthCare, Primary Care Committee, Appointed Member

EMPLOYMENT SUMMARY

Dec 2019 -Current	Star Health	Acting Chief Executive Officer
Oct 2018 -Nov 2019	Star Health	General Manager, Healthy Communities
April 2014 – Sept 2018	Thorne Harbour Health (formerly Victorian AIDS Council)	Director of Services
November 2012 – April 2014 (and previously September 2011 – March 2012)	Star Health (then Inner South Community Health)	General Manager, Organisational Support & Development
August 2009 – November 2012	Star Health (then Inner South Community Health)	Programs Manager, Mental Health, AOD and Counselling
June 2008 – July 2009	Victorian Government, Department of Human Services	Functional Expert, Client Management Systems, Office of Health Information
October 2001 – June 2008	Star Health (then Inner South Community Health)	Coordinator, Health Innovations & Partnerships Program
December 2000 – October 2001	Alfred Health	Manager Occupational Therapy Services/ Senior Occupational Therapist, Alfred Psychiatry

May 1998 – July 2000	NHS Trusts (Various, London, UK Based)	Senior Occupational Therapist (Various Mental Health Contract Roles)

Board Memberships

Nov 2017 – Current	Victorian Alcohol & Drug Association	Board Member
May 2012 – Dec 2016	Wilderness Society Victoria	Board Member
Feb 2002 – Feb 2005	Prahran Malvern Community Housing	Board Member