ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Held via Zoom

On Wednesday, 24 June 2020 at 9am

Before: Ms Penny Armytage AM (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Mr Stephen O'Meara QC
Ms Georgina Coghlan
Ms Fiona Batten

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I tried to connect with community mental health services but, until a crisis occurred, I got nothing.

People have told the Commission that even when they do gain access to services, these services are often not holistic. The Commission has heard that too often services fail to see the whole person, focusing on only one facet of a person's experience and failing to address others.

For example, as Associate Professor Dean Stevenson, Clinical Director at Mercy Mental Health told the Commission last year:

Your psychosocial supports and your psychosocial tools become lost with the focus on, well, what tablet are we going to give you now to see whether that will help

you or not?

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

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

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

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

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

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

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

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

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

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

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

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

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

Our second panel member is Associate Professor Steven

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

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

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

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

ASSOCIATE PROFESSOR MOYLAN: Yes, that's correct.

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

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

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

for the next two and a half hours. So, the proper pronunciation of your surname, have I got that right?

DR DEVENY: Yes, that's right, "Deveny".

MR O'MEARA: Thank you. And finally, Ms Bartholomeusz?

MS BARTHOLOMEUSZ: Yes, that's correct.

MR O'MEARA: Thank you. For the benefit of those who have come to watch this hearing, all panel members participated in a conclave roughly a week ago in which many of the issues the subject of today's exchange were discussed, but in the course of that conclave there were some areas or matters that were broadly agreed between the panel members concerning the topic of community-based mental health. I might just get each of you to confirm a group of those for me because they have been identified between you.

I'll start with the first three and then just ask one of you to confirm them. The first three are that, supporting the mental health of consumers is facilitated by integrated multidisciplinary care and a continuous model of care. Also, that there is fragmentation in the space between acute or tertiary bed-based care and primary care, and thirdly, that there's an important role for community-based treatment and support of mental health.

And now that I know how to pronounce your name correctly, Dr Deveny, can I ask you to confirm those three for me?

DR DEVENY: Yes, I'm happy to confirm those.

MR O'MEARA: Thank you. Then the next two are: community-based mental healthcare can have an important role in supporting consumers with mild, moderate and severe and chronic presentations as well as supporting families and carers, as well as that there are important (indistinct) issues of governance and funding. Ms Bartholomeusz, perhaps if I could get you to confirm those.

MS BARTHOLOMEUSZ: Yes, I confirm those.

MR O'MEARA: Thank you, and again finally, that there's a need to measure outcomes, not just inputs or throughput;

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

ASSOCIATE PROFESSOR MOYLAN: Very happy to confirm that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR O'MEARA: Sure.

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

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

client need.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

point to the system.

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

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

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

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

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

and accessing acute-based specialist care as well.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So, we absolutely work on building a relationship,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR O'MEARA: Stepped care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SHORT ADJOURNMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS BARTHOLOMEUSZ: Yeah, okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to outcome at all.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

those.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How do we do that?

MR O'MEARA: Yes.

MS BARTHOLOMEUSZ: Million dollar question.

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

MS BARTHOLOMEUSZ: That's right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

whether that be licit contribution to their presentation.

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

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

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

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

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

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

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

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

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

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

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

DR DEVENY: Yes, that's right.

MS BARTHOLOMEUSZ: (Nods.)

MR O'MEARA: Thank you all - sorry?

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

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

ASSOCIATE PROFESSOR MOYLAN: Ah --

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

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

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

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

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

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

trusting the services that are being made available to them.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

think that's changing.

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

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

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

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

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

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

COMMISSIONER McSHERRY: Thank you very much.

THE CHAIR: Dr Cockram.

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER COCKRAM: Thank you.

THE CHAIR: Professor Fels.

COMMISSIONER FELS: (Inaudible).

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

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

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

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

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

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

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

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

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

key goal for that is that the consumers feel better.

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

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

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

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

COMMISSIONER FELS: Thank you.

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

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

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

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

particularly into the future?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

very much.

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

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

MS BARTHOLOMEUSZ: Thank you.

THE CHAIR: Bye.

AT 11.55AM THE COMMISSION ADJOURNED

D

E

F

J

K

Q

R