Ian Hickie:
Good evening. I'm Professor Ian Hickie. I'm the Co-Director of Health and Policy at the Brain and Mind Centre at the University of Sydney. Thank you for joining us this evening for the second of our webinar series on flattening the curve, the mental health curve that is in response to COVID-19. This is part of a wider series we've also had about digital mental health, called 'Flip the Clinic.' In these COVID times we're now doing things very differently. Tonight, however, we want to focus on a major service challenge that we face. And that is in relation to the COVID-19 crisis. We will inevitably see increased pressure on our emergency departments. They're the place where the lights on and people are home, 24/7. Prior to COVID-19 we already had increasing emergency department presentations of young people in particular who could not find adequate care elsewhere. We're going to hear from a variety of people with lived experience and particularly innovations in this area shortly. I'm joined by a panel of presenters tonight, which include a range of professors and some of my favourite people, including Jo-An Atkinson, Jo Robinson, Simon Judkins, from the College of Emergency Medicine, John Mendoza, Pat McGorry, and Elizabeth Scott, who's joined me here in our lounge room as we go to the world, from our own particular places.
I would like to start by also recognizing the Gadigal people of the Eora nation and myself and Elizabeth sitting in the beautiful part of the world in Sydney, which is the Gadigal people's world where the University of Sydney also has its principal campus, and also the pay our respects to those who have lived experience of mental health problems. If you're joining us and you have questions you wish to ask, you can use the Q&A function and I'll attempt to reply to many of those as we go but also bring to the attention of our panellists.

So some of you will be aware that we have created some degree of national interest in the mental health curve, the second curve and the predictions about the size of that curve that's caused the degree of disturbance to some that the idea that we simply are saying that things will get worse, may or will cause our system to come under more pressure, our system will come under more pressure. The reality of these situations is I think my own view is we're in the eye of the storm at the moment we've been through good fortune and good governance been able to dodge the bullet of the health crisis of COVID-19. But the economic recession effects and its effects on mental health, and the ongoing mental wealth of our nation is a major challenge. What we're looking for is solutions. What we're looking for is innovation. What we're most looking for is a coherent national response. And in order to inform that will shortly go to Professor Jo-An Atkinson, who's led that modelling. But for all of us, there's a real world element to all of this and so very kindly David, who is the parent of a teenager who first started to pass through a mental health system when she was 14, but as recently as last weekend was against taking emergency help from our system, has kindly agreed to share his experiences of the acute aspects of our mental health system. So David, it's a great pleasure to have you with us. I wonder if you wouldn't mind starting by just giving us a little bit of an idea of what it's like, as a dad to take a 14 year old daughter repeatedly over the next few years, in fact, back to our acute mental health system to our emergency departments, and what that experience is like.

David S:
Thank you, Ian, can you hear me Firstly.

Ian Hickie:
We can, very loud and clear

David S:
Okay, excellent. So, I mean, the short answer is very, very difficult and very disturbing and it leaves one feeling quite desperate. So my daughter has had OCD since she was about five years old and this has been going on for years and years. It got particular bad, probably towards the end of 2015 and I had to navigate the mental health system she was with adolescent services and try to get her into hospital. And that was an incredibly difficult task, trying to navigate all the procedures and the requirements and eventually through sheer perseverance on my part and also a particular psychologist who was invested in it we managed to find a bed for her at a unit and she was admitted there for a number of weeks and that did her the world of good but in the time since then she's had ups and downs and various periods during which has been okay and then various periods during which it's gotten worse. And we've had countless countless trips. I honestly don't know how many to the emergency department. The way her OCD manifests itself is that she becomes, she will have a panic attack, she will start to scream desperately thrash around on the floor, smash things. You know, very extreme behaviour. And obviously, it's very disturbing at home, she's got a younger sisters, very disturbing. And we've had police and ambulance here multiple times.

She's been taken to the emergency department, many, probably most of those times under the Mental Health Act, the schedule of the Mental Health Act, because she was deemed to be at risk of serious harm. And then through the normal process, she goes to the ED waits there about something between eight and 10 hours before being seen by a registrar. And then at that stage, she may have calmed down, and then they don't deem her anymore to be at risk of serious harm. I was even told on one occasion that they couldn't take into account the report of the police that brought her in, because she has to be presenting as a serious harm right at that precise point in time. So it's been very, very difficult to get admitted to, usually it's like a revolving door, we get sent back home again. She was admitted last year on two occasions to a to an adolescent unit. For the first time for three weeks, and that did her a lot of good. But there was no there was no real follow up. And, then she was admitted a second time, but then decided to leave after five days because she felt that it wasn't helping. And of course, she wasn't being held against her will at that stage. And so she left and then she was admitted a third time. And they discharged her because she was finding it too difficult to do the things that they wanted her to do, which was the very reason she got admitted in the first place. And then we've had up until this very last weekend, multiple more visits to the emergency department. Now that she's turned 16 she's treated as an adult. And so she's been at the PEC unit I think that stands for psychiatric emergency something or other, unit at two different hospitals and on both occasions. She was either not admitted or discharged very quickly, on one of those occasions had actually gone to the gap and threatened to jump. And two days later, they discharged her and said that she wasn't at risk of serious harm. I pressed them on the issue and I was told that yes, maybe she was at risk of serious harm, but they were an adult unit and therefore not suitable for her. But she's treated as an adult under the Mental Health Act so we are in this void, she's 16 and treated like an adult that they tell us that they are not suitable for her

Ian Hickie:
So David, you were telling me earlier on about treatment going on in different hospitals where in some hospitals, the lack of communication between the emergency department and even the adolescent services at a hospital. In other hospitals, you're told she's too young to actually go into the services of that hospital. You know, this kind of issue and I think you did use the word if you don't mind me saying so, the system appears broken. This lack

of cordination between these, particularly for teenagers, particularly young people you are a round peg and we don't have a square hole that you fit in. You know that frustration, could you just share with us a little bit of that frustration as a parent point of view when we fail to respond, and then you the family are somehow supposed to sort it out?

David S:
Well, yes, this very last weekend in fact, she was going through a difficult time and various things happened and again, got taken by ambulance to the emergency department at a certain hospital, and then got admitted, not admitted, but taken to the PEC unit at that hospital, which is the adult psychiatric emergency section, as I understand it, and, you know, we had long discussions with them. And they said they could probably keep her in for a night, but then she'd have to go into the adult Ward, which they said wasn't suitable because you've got adults strangely enough, having all their own issues, which they didn't think it was suitable to expose her to, because she's only 16. And then there was discussion, I raised the issue as to whether she couldn't be transferred to the adolescent unit at that particular hospital. And I was told that even if they were a bed available there, it would probably take five or six days for them to be able to do such a transfer. I found that absolutely incredible because it's the same hospital. So we ended up coming home again. So I don't know if that answers your question.

Ian Hickie:

Yes I think, David, that pretty much summarizes the level that we've reached in our systems. But I wonder if you could say, there are many issues we were discussing some of the legal earlier and practices. But if there's one or two highest priorities, that you as a parent, who is trying to negotiate here on behalf of a distressed and disturbed young person would really put emphasis on us to focus on, you know, is there one or two really highest priorities from your point of view?

David S:
I would say probably indirectly, the highest priority would be resources, because the way I see it, from the paramedics through to the psychologists and the doctors, they all interpret the law very, very narrowly. So I understand that the Mental Health Act talks about risk of serious harm. But what they take that to mean is, is a risk of imminent actions towards suicide. So I've actually been told in so many words that cutting oneself doesn't make the grade. So why are they not taking in people who are clearly at risk of serious harm? So maybe that's because they don't have the resources and the bedding. So I've been told that, you know, numerous occasions that they weren't beds available, and that, you know, that could make it very difficult. So, I would say probably the first thing is combination between having enough resources, but also having a more appropriate interpretation of the actual law, rather than had been so narrowly interpreted. Because I mean, she's really suffering and we as a family are really finding it profoundly difficult. Just to say she hasn't actually been to school for about a year now, essentially, has spent the last 10 or so weeks lying in her bed, sleeping through the day, waking up at night. For a few hours and then going back to sleep again, so she's been completely disengaged with society. I mean, I would have thought that that is serious harm to her to a 16 year old, but it's not treated as such.

Ian Hickie:
Okay, David, I want to come back to you at the end. After you hear what everyone has talked about the see whether you think we're all on the right track.

At this point on a move to Professor Jo-An Atkinson, who has been leading our modelling work as to what the situation was Jo, in much of rural and regional Australia, what's been the base of a national model, pre COVID. And what we might expect, actually, as the covid crisis, particularly economically and socially, actually plays out.

Jo-An Atkinson:
Thank you, David for sharing that story. It really kind of is consistent with some of the lived experience perspectives we were getting when we were doing this participatory modelling project and really helps ground some of the work that that we've been doing. So last year our team in partnership with North Coast Primary Health network, and with over 50 local stakeholders, collaboratively built a systems model for the region. Next slide, please. And modelling is such a ubiquitous term and there's been some misunderstanding about this type of modelling, so I'll just briefly introduce the basic architecture of system dynamics modelling. So there are stocks which are quantities and in this case, a stock is a population, and there are flows which are the arrows which are rates of inflow and outflow from the stock. So in this simple example, the population changes over time depending on what's being added to the population through births and migration and what's being subtracted from the population. So just like a bathtub whose water level rises if the quantity of water flowing in from the tap is greater than what's escaping from the drain and vice versa. Next slide please.

So from these very simple building blocks, we can represent health systems and social systems and the flows of people through them and the factors that influence those flows. And in this example of the mental health system, when we run the model, the proportion of the population waiting for services or receiving services is changing over time based on the different rates of flow into, within, and out of the service system. Next slide, please. So if we zoom out, this is a high level overview of the causal structure and pathways of the north coast model and you can see the interconnections between the psychological distress component and the mental health services component and the key social determinants of mental health. So when unemployment goes up, not only does it have a direct effect on the rates of high to very high levels of psychological distress, which has knock on effects on the rates of substance misuse and adverse early life exposures and service demand, but it also affects the rates of domestic violence and the rates of homelessness, both of which further exacerbate levels of psychological distress and so on. And these are the feedback loops that drive the vicious cycles and the virtuous cycles that exist in the real world and only through systems modelling can we really understand and explore how best to invest adequately to break these vicious cycles and reduce pressure on our mental health system and set us on a path of improved outcomes and healthy communities. Next slide, please.
So this is just a slide that shows that the model is able to reproduce historic data across a range of indicators so that we can have good confidence in its forward projections. Next slide, please. So this is the interactive interface of the model that facilitates scenario testing, and the last webinar focused on forecasts for suicides in the region but we're also going to see increased pressure on our health systems through mental health related ED presentations and self-harm hospitalisations. And under the pre COVID scenario, mental health related ED presentations and self-harm hospitalisations per year were already rising, and forecast to rise further before plateauing in 2021 -2022 with an estimate of 42,700 ED presentations and 6300 self-harm hospitalisations projected between 2020 and 2025 in the North Coast region alone. Next slide, please. So we then ran a scenario that mimics the social and economic impacts of the pandemic and subsequent recession with the assumption of a peak total unemployment rate for the region of 11.1%. which is the red line, and a peak youth unemployment rate of 24%, which is the orange line, and a pattern of

unemployment that you can see in the graph with the peak occurring later this year and then declining thereafter. And we also assumed a 10% reduction in social connectedness as a result of lockdown and also the isolating effects of unemployment. Next slide, please.
So under this set of assumptions, the model forecasts an increase in the prevalence of high to very high levels of psychological distress in the community that doesn't return to pre COVID levels within the next 10 years. Next slide, please. We're also likely to see a 15% increase in mental health related ED presentations over the next five years. That's an additional six and a half thousand ED presentations for the region. Next slide, please. We're also likely to see a 20% increase in self harm hospitalisations in the region over the next five years, which is over 1200 additional people attempting to take their own lives. But it doesn't have to become a reality. We can use this model to test strategies that will help us realise a different future. In the same way we use this kind of modelling to avert the full impact of the COVID-19 pandemic in this country. So what will it take to bend this curve? Next slide, please.

So when we simulated a 20% increase in the current growth rate of the community-based specialist mental health services, it resulted in only 0.8% reduction in mental health related ED presentations from 2020 to 2025. However, the impacts do increase over the longer time horizon that's shown in the graph. Next slide please. It also results in only a 0.4% reduction in self harm hospitalisations over the next five years. Next slide. If we increase the growth rate in community by specialist mental health services by 50%, this results in a 2% reduction in ED presentations over the five year period, but over the 10 year time horizon, it brings ED presentations almost back down to pre-COVID baseline levels. Next slide. But it only results in a 1% reduction in self harm hospitalisations over the next five years. Next slide. It's not until we double the services capacity growth rate that we see a more effective bending of the curve with the 4% reduction in ED presentations. Next slide. But this still only reduces self-harm hospitalisations by 2%. Next slide. If we supplement services capacity growth with improved care coordination enabled through digital technologies, it more than doubles the impact of services capacity growth alone, producing an 8.5% reduction in ED presentations and taking us to below pre-COVID baseline levels within the next few years. Next slide. It also more than doubles the impact of services capacity growth on self-harm hospitalisations producing almost 5% reduction over the next five years. Next slide.

And if we add to that combination post suicide attempt versus assertive aftercare, it has little impact on ED presentations, next slide, but it does have a significant impact on self-harm hospitalisations delivering an 8.8% reduction over the next five years. So these strategies to try and help flatten the curve could further be supplemented by initiatives that are not currently included in this model, but the model can be expanded to in the future to be able to test a broad range of initiatives. And I'll just end by emphasizing that the timing and combination of strategies to bend this curve are important and should be tested in the safe environment of a systems model before being implemented in the real world. Thanks.

Ian Hickie:
Jo. That's marvellous. Professor Mendoza, who's joined us - are the people responsible for the systems yet alarmed? I'm alarmed. I mean, anyone as a parent as I am. And Liz and I are have teenagers and young people in these kinds of settings, we don't understand the scale of what we're talking about. And I think a point that you're making, I think David's own experience, including last weekend, it's a system under pressure already. And that pressure, of course, led to the referral of the mental health system to the Productivity Commission by the previous government, to the Turnbull Government period when the current prime minister was the treasurer, and they are due to report on June 30 this year. Concurrently, we

have a royal commission running in Victoria and I want to invite Professor Jo Robinson now to speak about the work that Orygen has led, and we have had Pat McGorry join us and we'll get to some other innovations here. But, Joe, I suppose the reality is that Victoria with its Royal Commission, its state services is probably the state at the moment that is struggling most to really come to terms with this, how to organise itself, what will happen, and a big driver that was a recognition of emergency department pressures and presentations. You've been working a(nd we'll come to Simon Jenkins shortly) with emergency departments, on protocols on approaches, particularly around young people in these areas. So why don't you could share us with some of the experiences of what's driving that work in Victoria and where some of the ways forward might be that the Victorian Government is now considering funding at scale.

Jo Robinson:
Yeah, absolutely. Thanks, Ian. And Good evening, everybody. So I'll talk a little bit about some of the work that we are doing in Victoria, and what we're hoping that that will achieve, and also kind of ultimately, we're hoping that it will lead to improved experiences. So David and other people like him and his family don't have to experience what, what he's been experiencing. So we're doing a big piece of work, partnering with a number of emergency departments across Victoria, to really understand, you know, who's presenting to emergency departments with self-harm, what are they presenting with, what sort of treatment they get, and how that we might work with EDa to start to improve practice. So what you can sort of see here on the slide is that we're starting to develop a self-harm surveillance system, and work towards best practice models here in Victoria. So we're doing that by sort of aiming to really understand the epidemiology and the frequency of self-harm presentations, but not just by young people. We're very interested in young people, but we're actually doing this across the age range. So what do those presentations look like for self-harm in Victoria, partly to understand them in and of their own right, but also to develop perhaps a lead indicator towards how we're doing in terms of tracking towards reducing suicide rates as well across the state.

We're looking at what the gaps might be partly in terms of data collection, but also really in terms of patient care. And then we're trying to understand what some of the barriers are to delivering optimal care that, you know, we've heard David talked about already. But what are some of those barriers from the perspectives of staff, young people and their families and ultimately, as I said what we're hoping to do is improve outcomes for young people, improve data collection, but also maybe work towards a real time response so that when we are seeing increases in particular types of presentation to hospitals, we're actually able to provide a community level response in real time.

So what are the benefits of self-harm surveillance systems? So there are a number of existing self-harm surveillance systems around the world, probably the longest standing one is based in in England, and we do have one here in Australia, but at the moment, it operates in the Hunter New England area in New South Wales, but only really looks at self-poisoning presentations and intentional overdose, so it doesn't really span the whole range of problems or methods of self-harm that people have used that we that we'd like to better understand, I guess. So there are a number of surveillance systems that exist in the world and they have led to all sorts of useful things, I guess. So they've led to improvements in practice and policy. And in the areas where they exist, they've been able to guide evidence-based practice and policy, they've been able to guide the development of those protocols, Ian, that I know you referred to earlier, they've been able to really guide what appropriate resourcing might look like. So for example, we know that a lot of the presentations by young

people to ED happen at night, and when EDs are perhaps not well resourced, with mental health staff, so we can really guide when we might need better, you know, or more resourcing in terms of staffing, etc. And they've been able to kind of lead to improvements in the quality of assessments and treatment that young people receive when they do present.

They also have lots of kind of research benefits as well. So you know, I'm a researcher, and we're very interested in things like the epidemiology around self-harm, what the rates are of self-harm, what the rates of repetition are like, what's the relationship with subsequent mortality. So for example, by suicide, what types of methods of self-harm are people presenting with? But probably more importantly, they allow us to then evaluate these sorts of systems, allow us to evaluate the impact of those practice and policy initiatives. So we know that, you know, if we're spending a lot of money and resourcing and you know, fortunately, we are, you know, we've got a lot of attention being turned to this here in Victoria. But how do we know that what we're doing or with what we're spending money on is the right thing? How do we know it's impacting on outcomes, better outcomes for young people. So these sorts of systems allow us to evaluate those much more easily. And they also allow us to evaluate or to assess the impact of, of major events, for example, like pandemics, so we get asked a lot, what's happening emergency departments now, in the context of COVID-19, are we seeing increased or decreased presentations, and these sorts of systems will be able to answer those questions. So if we could have the next slide, thanks.

So what we're doing is we've got eight study sites across Victoria, we're working with a number of six Metro sites and two regional sites. And at the moment, we're getting data from those sites quarterly. We apply some text mining and machine learning algorithms to the data that we receive in order to identify who are the self-harm presentations. And then we cross check that with case auditing, and file auditing protocols, in order to make sure we're not missing the wrong people. And, you know, we're not counting the wrong people basically.

Next slide. Thanks. So that's kind of what we're doing in terms of kind of setting up a surveillance system which we hope will speak to other systems across the country. And really, we'll be able to move towards really strong robust data on self-harm presentations, but we also hope it will lead to improvements in practice. So we've been working with staff in the emergency departments and talking to young people and you can see a couple of quotes from the young people up on the side of the slide there. But really what these sorts of what this work is telling us is that what we need to be moving towards is better education and training for our staff, and we are doing some of that work with emergency departments at the moment. But people are really crying out for youth friendly settings, really clear protocol management when young people with self-harm present or present to EDs with self-harm, in the same way that we have protocols in place when people present with chest pain. We need those same sort of protocols for people when they present with self-harm. We really need to be moving towards collaborative and psychosocial assessment and ongoing safety planning with people when they present and then streamlined and fast track referrals into appropriate systems of care depending on what the needs and wants are of the people who are presenting. And part of that is is what Joe alluded to earlier which is around assertive aftercare and again, we know that the Victorian Government is investing in that going forward as one of the outcomes from the Royal Commission. But those, those sorts of systems need to be youth friendly. They need to be based on best practice. And they need blended models of care where we're, we've got conditions working with peer workers, we've got face to face, and we've got digital interventions working together. And as I said, you can see some of the quotes up here, and one of them really speaks to the point I think that David

was making earlier. Whereas it wasn't enough for a young person to express that they felt at risk. They had to really be seen to be being at risk before they could get treatment. And we've had young people say, you know, how suicidal or do I need to be before getting the treatment that I'm asking for. But on a more positive note, the other quote, talks about some of the positive experiences and what young people were able to reflect in terms of what worked well. And some of that shouldn't be difficult to resource. It was really some of those softer skills that we know are so important in terms of, you know, listening and paying attention and really appearing to care, taking a holistic approach to understanding what was going on for the young person, not diving straight into what we might refer to as a as a risk assessment.

Next slide. Thanks. So in terms of some of our next steps, we've got Dr. Cat Wit working with us who's recently been awarded an NHMRC grant to do some work that will also be working alongside the CRE that we've got together with Brain and Mind Centre. And together we'll be developing some data linkage systems to really establish and understand individual treatment pathways following an episode of self-harm. So what happens next, linking up the ED data with other sources of data, we'll be looking at the effectiveness of different treatment pathways or interventions on rates of self-harm repetition and suicide via suite of kind of clinical trials and and using the modelling that Joe has just spoken about, and then really looking at developing some alternative health pathways and treatments that are fully informed by evidence, and will be very much working in partnership with people with lived experience as we as we do that work.

The next slide. So just to bring all of that together, really, I think the current pandemic has really highlighted the potential value of real time monitoring when it comes to health. Imagine if we haven't had the real time data collection that we've been lucky enough to have around our physical health. And what we're working towards is having some of that real time monitoring for self-harm and suicide risk as well. We need to explore novel and linked data sources for suicide and self-harm surveillance, so looking at expanding, for example, some of the state based suicide registers, how we can make those more accessible and more timely, so we can use that data in a really meaningful way in real time. And there is some work going on around that currently at national level here in Australia, and you know, and you know, we'll be very excited to see that kind of scaled up, but we need those things to be linked to the testing and implementation of best practice protocols and treatment, if we're really going to make a change to, to people's experiences when they when they do present. And I will leave it there. Thank you.

Ian Hickie:
Thank you so much, Jo. And you've just introduced a very important part of what we do, which is the National Health and Mental Research Council's Centre for Research Excellence that we have for youth suicide prevention and it focuses on these pathways to care. And a very important member of that team is Dr. Simon Judkins, who's the immediate past president of the Australian College of Emergency Medicine and during his presidency, to our great benefit, he led a very important national movement to the recognition of the importance of mental health within emergency departments and emergency room physicians, being at the front of this particular drive. So I'm, I really want to know I'm a middle aged man, I go to emergency departments not infrequently with a certain kind of heart problem. And there is a protocol in place. I know I'm not going anywhere, until I'm well assessed, until I'm safe, until I'm connected with good care. Because there are protocols, there are standards, there are issues in place. Can we ever hope to achieve that same kind of standard of expectation of

care for mental health presentations for self-harm, and I guess particularly we focused on presentations in young people.

Simon Judkins:
Yeah, thanks. And thanks for inviting me to come and participate today. So I suppose I just want to give you a bit of an idea about, you know, what's been happening with mental health presentations in the emergency departments across Australia, where we are currently, and I suppose the importance of the work we're talking about now because after listening to the first couple of presentations, and having just finished the day working in a busy emergency department, my heart rates is mainly jumped up to about 140 beats a minute, just because there is a heightened sense of stress within the within the system now, which is just going to get I think, even more and more stressed unless we get some fairly urgent actions on some of the initiatives that we've been talking about. So we know that looking at mental health presentations across the system for the last 10 years have been going up and up and in every state and jurisdiction, and they're increasing faster than our general presentation. So you can see that there's been growth year on year at 3% of presentations across a days, that mental health presentations are growing faster. And in fact, if you look at it on a per capita basis, over the last there's been almost a 60% increase in presentations on a per, on a per capita basis, over the last five to 10 years, where people come to EDs with their mental health presentation. So it's certainly putting the system under a lot of stress.

Next slide please. And so looking at the demographic data in a bit more detail, you can see there, around a third of the presentations are 18 to 34. So a large cohort of patients presenting in that age bracket. I haven't looked at the adolescent data there, but certainly we're seeing an increase in adolescent presentations in EDs also about 50/50, male and female. We're saying a significant proportion of Aboriginal and Torres Strait Islander presentations disproportionate to obviously, the general population. Obviously, there's an issue about socio economics, the lower two socio economic quartiles presented there half of the presentations. Although a large number 66 presenting 66% of the presentations are in major cities, we see that EDs, particularly in regional rural areas, are really a focus for mental health presentations. Unfortunately, in those areas as we know, the resources available for mental health care in regional rural areas is significant and this is where we're really seeing some of the issues around patient spending long times in a Eds waiting for transfers. I was recently working up in a regional area where we have an adolescent waiting for a mental health bed, who waited three days in the emergency department for a bed. So, you know, coming in with mental health disorders, self-harm, and spent three days waiting to be transferred to an inpatient, an inpatient unit. So which is obviously, clearly, and as we've heard from David, that's clearly damaging to that poor young lady.

Next slide, please. So the experience of patients coming to Eds: They're more likely to arrive in police and in correctional vehicles, more likely to run, be run by an ambulance, less likely to be seen in the time, and that goes back to the point you're making Ian that we don't have clear pathways. We have protocols for acute myocardial infarctions, we have stroke protocols, we have toxicology protocols, but you know, our protocols for mental health presentations clearly aren't as robust as those other physical conditions. Patients are more likely to wait longer, they're more likely to stay in for 24 hours. If you look at 24 hour stays in emergency departments across the country which are increasing, despite our advocacy, they're almost purely patients waiting for mental health care and mental health beds. So that problem is growing and growing, and sadly, more likely to leave at their own risk without a definitive care plan, without actually getting a proper mental health assessment and clearly without appropriate outpatient or community-based follow up.

Simon Judkins:
As you can see they just emphasized the issues around the waits. We are working in a system that is overcrowded, that is increasingly stressed and that doesn't actually have the capacity to be able to absorb the workload that continues to present there. And once a patient is deemed to be in a need admission into a mental health bed, you can see they say an incredibly long time for that. If you compare mental health presentations or admissions to other admissions, in 90% of our admissions to hospital wards for non-mental health presentations get admitted within about 11 hours. For mental health patients, you can see that blows out to almost 18 ours and as I said before, almost exclusively, patients stay in longer than 24 hours in emergency departments and mental health presentations. And we've heard stories from across the country of patients, as I said before staying three, four and five days in emergency departments waiting for inpatient bed. So clearly, it is a system that is fractured and a system that just doesn't have the capacity to absorb the workload that's presenting through our ED doors.

So again, we realize that within the emergency departments, there was a lot of work that we need to do. The emergency department clearly isa very difficult environment for patients and as we know, and as David has said as well, that is clearly not a therapeutic environment. Unfortunately, it seems to be in our current environment that all roads lead to the ED. But we also recognize that the ED is not a very therapeutic environment for patients and that data that we just presented and really sort of supports that. So certainly it's an inappropriate environment for somebody who comes in with a crisis because we certainly don't have the infrastructure to be able to support people in a quiet and Is I said in a therapeutic environment with extremely long waits, but unfortunately, most people that do come, come with a sense of trepidation because they really don't know where else to go.
So the reasons for this, and I think we've alluded to some of that already, that there's a lack of crisis services available 24 hours a day, there are insufficient mental health beds so when patients do need at admission, and ideally, obviously, what we would like to be able to do is make sure that people don't need to be admitted and where they want to access the care that they need within the communities, but they're just insufficient mental health beds in the way our current system works, and that means that patients are not only having long delays to admission, but they're probably getting discharged out the other end because of the pressure on the front end. I've often heard managers of mental health units say they just feel like risk managers, they're trying to get the risky patient in the ED in, and they're sending the less risky patient who might have had a one or two or three day stay back out into the community without that link back into the community for their ongoing care. As I said, clearly, there's inadequate capacity in the community and also a need to ensure we further enhance or support primary care for mental health.

So our goals from an emergency department perspective is really to be an advocate for the system to ensure that when patients do need to come to ED that we actually have a therapeutic environment that we can offer them and make sure that they are woken, they are looked after, they are treated in an appropriate environment and not in the daily hustle and bustle over a high volume, stressed, emergency department.

So the way we want to do that is obviously we want to create some standards in our emergency departments working with other partners within the system. And that's about improving standard of care in the emergency department. And again, and David alluded to that, but that we'll be looking at ensuring that we do have pathways and processes, Ian as you said, that look at really giving us guidelines about getting patients through this system, effectively getting the right patient to the right place at the right time. Having peer workers,

for example, working in emergency departments, having time basis expectations on length of stay in emergency department. We're looking at implementing alternative models of care, which includes things like mental health hubs within a day's route because we're building our infrastructure because it's certainly not a one, you know, EDs are very much a one size fits all environment and we recommend to recognize the particular needs of different patient groups and ensure that we have increased availability of crisis services within the community and also ensure that people know how to navigate the system and I think we've made that point a number of times that you know people and their families, patients and their families, people with mental health crisis, the system is very hard to navigate. There are plenty of examples of patients trying as hard as they can to get to the right place but either the appointment is in three week's time, it is across the other side of town and they don't have a car to get there, or they just simply can't afford it. So unfortunately, all roads end up leading to the ED. Thank you.

Ian Hickie:
Thank you so much, Simon. And highlighted you know, the pressure emergency departments and for those who don't know, I've had the pleasure ringing Simon on Sunday morning and he stepped out from a cardiac arrest to talk to me and fortunately gone back to help the cardiac arrest. He is on the front lines of these issues and his leadership in the area of emergency departments has been one of the drivers, for the emergency department is that last resort, we're not saying it's the optimal resort. Clear system [*inaudible]* required to relieve pressures.

Now the next two speakers, John Mendoza and Pat McGorry, are both looking at ways of trying out alternative models to these emergency rooms being the only last resort that is active in acute care settings. So John has recently moved from the warm climes of Queensland, the COVID free warm climes of Queensland, to South Australia to take on these sets of problems right in the middle of what we'd call the emergency room crisis in Royal Adelaide Hospital and the Central Adelaide Local Health Network. So John, having gone to Adelaide to really the heart of one of these crises, to a brand new hospital that actually doesn't necessarily have the functional capacity and looking at real alternatives. What are your views?

John Mendoza:
Thank you, Ian. And Hello, everyone. Nice to be with such august company tonight. Well look, I'm still getting used to the temperature in the Southern Ocean I've got to say. It's a challenge coming from the Coral Sea.

I wanted to just sort of come out from where Simon was looking at the data. We know things are challenging, but I would say that the variance in ED performance across Australia is rather striking. And you know, even here in Adelaide, I can look South at Flinders Medical Centre and North at Lyell McEwin, which I had a bit to do with in trying to set up an alternative pathway in that area a few years ago, and can see vastly different performances. And one would argue that the northern suburbs of Adelaide with the loss of the car industry and manufacturing virtually gone, faces much greater social determinant pressures driving people to ED than here in central Adelaide, although we have a very large disadvantaged population in the west of the city as well. A couple of things I want to start with, I just tried to pull a slide out of a report that I did for the executive and board here in Adelaide last year. And it really looked at globally, what are the key strategic approaches because this is not just an Australian problem. This is a very big issue in the United States. And over an 18 month period, I was part of a, what we might call a community of practice with 11 leading

organizations in the US including a cluster of 11 hospitals in the South Sacramento Valley, which work very collaboratively together and Kaiser Permanente really is the backbone organization that's supporting that group working with UCLA Davis Medical Centre. And looking at those models and looking at the best practices here in Australia and places like the Alfred in Melbourne, St Vincent's in Sydney, Charles Gairdner in Perth, we can see that there are a number of approaches that hospitals are using to try and respond to this challenge in this surge in presentations or people in crisis, and these crisis presentations are not a greater number of psychoses, there are some drug related psychoses that come and go, but these are people that are driven by their circumstances to end up at an ED because their lives are falling apart and they are in the biggest crisis of their life and they don't know where to go and their friends or family or police or ammo bring them to the ED. And as Simon said, it's not a particularly attractive or compassionate therapeutic environment when you are experiencing that sort of crisis.

So they're the four categories, but what I'd say is that the sort of core of it is where we're seeing success in this space in stemming this demand and managing in a more compassionate, therapeutic way is that we shape demand. We try to use a number of levers to shape the demand that presents at the door. So we work on root causes in coalitions, in collaborations, those sorts of things, to work as far upstream as we can to influence the drivers of despair. We then have to focus on how do we match the resources that we have available? In any health system, there's a cap on how much resource we have, and how do we match that resource to the demand. So we've got to apply the models of queueing theory, of scarcity, of flow, to really do that as effectively as we can. And these are not commonly understood principles and approaches in our healthcare system. People simply want to continue to ask for more, or continue to do the same practices. I do not see a lot of innovation other than those few hospitals that I mentioned around the country in the way that we're responding to this. We continue to apply the same sort of consultant liaison psychiatry into ED. It's a failed model. It belongs in the in the, you know, the memory box from last set century. I do not see the innovation in the infrastructure that we see in the US and elsewhere in Australia yet. We still build large, multi-cubical EDs that are fit for people with strokes, with heart conditions, you know, other stomach problems or whatever, but they're not built for people with psychological problems. So we've got to match the capacity to demand, we've got to match the settings, the infrastructure to the demand, and we've got to match the philosophy of care. We must change these things if we're going to see different outcomes. With where we're going in Adelaide, I'd have to say that in Central Adelaide serving a population of about a half a million in this city, that CAHLN represents about 40% of the State mental health capacity, so we do a lot of services for the regions as well, but essentially what I'm trying to build and work towards which the Board endorsed as a high-level principle in a sense, is understanding that we have to build an ecosystem of care that we transition people through this system to the most appropriate setting for care. Now at the moment, if you appear at the Royal Adelaide or any other acute hospital in Australia there's more than a 50% chance you'll be discharged to nothing! Nothing! You won't have a discharge plan, you won't have any connection or warm hand over. You just make your own family with your family back to whatever distress… and David's story was illustrative of that earlier on. Now this is an incredibly common experience, everywhere around the country. The second thing is when you are discharged from the inpatient unit, the follow up care you get is lousy! Its highly variable, and we know, the evidence is over whelming that the first seven days… In fact, the evidence in Queensland is very clear it's the first three days after that discharge from inpatient care, you are in a very, very high level of risk – the highest level we know is in that period. And, yet we still can't connect care to that group of people. This ecosystem really describes a different way of responding and no one is discharged to

nothing. Everybody transitions to care. And, that has to be a founding principle, a philosophy that we adopt. And so, this shows a system where we have a collaborative governance with shared metrics. We are all trying to achieve the same thing as a group of entities, organisations trying to provide continuous wrap around care for people in crisis.

If we go to the next slide [Our Value Base Urgent Care Model]. This is then an example of this taking one particular service innovation. And what I see consistently around Australia, in responding to the challenge of this surge in crisis presentations is we see some kind of a bolt-ons. We see a café bolted on or we see some other thing that is bolted on… you know the silly way back program… high cost, low impact sort of program. These will not work. You've got to have this philosophy of a systems approach and use data to drive the thinking around it. So we are looking at an urgent care centre within walking distance of the Royal Adelaide and its built on this same flow and consistency approach. So, if you enter this centre, you will be connected to something. We will use smart technology – the InnoWell Platform will form a core feature of this and with peer workers chaperoning the person throughout the care journey to the most appropriate setting… and you can see where the people are coming from to the Urgent Care Centre, linkages are with the street interventions (what I can street interventions), that's the safe hold, the police, the sas, the ambulance, the mental health triage… sorry the mental health crisis teams in the community. They are the street interventions where we are trying to again keep the person away from if you like or keep the person in the community as best we can and wrap the care around them in that setting. GP Liaison is another service we are proving into that space very shortly. And you can see that all of this is underpinned by digital integration, by data and shared decision making and collaborative governance.

Can we move on please to the next slide [Internal Consumer Flow/ Journey]. So, this Urgent Care Centre that's the patient flow. The concierge – two minutes – you appear and you are seen within two minutes. You are offered a digital assessment, a comprehensive digital assessment, or if you don't want to do that, a face-to-face assessment with a peer specialist. There is no clinician in sight and there is certainly no security within sight, within this centre. You can continue with the peer specialist

Ian Hickie:
Can you just emphasis that? People have raised this in the Q&A's in concert with us. You are going to use peer specialists to support these assessment processes?

John Mendoza:
From the get-go Ian. So, the chaperone is the peer specialist throughout the journey on the left side of that slide – the peer stream. The clinicians come into the stream, the allied health, the social workers, the nurses, they come into it to support that peer worker in the work that they are doing with that client. And that client might be in that centre for 4, 6 hours and then they are moved to another place, another setting, another service. If they need an acute admission, then that's fast tracked. They by-pass ED, there's no going to ED again after you have been through this. And, we will have patient transport, that's appropriate for them. No alarms and bells and whistles going off that further traumatise people. The point that I would take from what Simon said before as well, he said "the vast majority, I forget the percentage you had there Simon, is a very significant number of people in that under 34 age group presenting in crisis". Now we're traumatising these people. We're diminishing the opportunity for them to engage with services in the long term. We're failing them at the very first hurdle. We've got to over-come this. We've got to be a welcoming and inviting, a positive experience from the word go.

I've muted myself. Next slide please Grace [World Leading Digital Platform]. So, the digital platform is a part of this. It's not the solution, it's going to be underpinned by the continual modelling and data collection that informs the way we refine the systems within this. So, the way this will inform how we change the co-responder models that are located with the police and ambulance. The way we deploy the GP Liaison into the community. All of these will be informed and tweaked so that they integrate and work together, not as separate entities. This is the failure that I see around the country. We continually go to a program response… We Don't Think Systems! [Thank you for your time slide]

Ian Hickie:
Just in case anyone didn't catch that in relation to the InnoWell Platform. I have a conflict of interest to declare in relation to the InnoWell Platform – it's a spin-off of the University of Sydney and PwC, in which I have a small equity shareholding. But John is bringing the issue about what we've modelled elsewhere about IT collaborative systems of which there are many. Sharing information and guiding people through pathways. Clearly John in a most challenging situation which has been created by the birth of Royal Adelaide Hospital and the concentration, you are attempting to provide realistic alternatives, fast admissions for those who need admissions, alternative pathways, not relying on everyone having to go through the ED particular setting. And the inclusion – Pat McGorry will address in just a minute – the inclusion of peer workers as part of the journey. Not instead of clinicians, but alongside clinicians as part of the journey.

John Mendoza:
Correct, the key thing Ian is that its about setting up alternatives. This is about how we shape demand. Not all roads lead to Rome… or the Royal Adelaide in this case. You've got to create other pathways.

Ian Hickie:
I've never thought of Adelaide as Rome, but I'll keep that in my head from now on. Just for those who are joining us, we were planning on finishing at 7:30 and there are a number of other important perspectives, so if you stick with us we will continue a little bit longer. Last, not last, second last but not least, Professor Pat McGorry has joined us and I know that he has been very busy on the case of the Treasurer and other people this evening about investments in mental health… But Pat, I don't know that everyone knows, your so world famous for early intervention that you really started down that line to reduce the trauma associated with hospitalisation particularly of young people and the trauma that John and others have just mentioned of their ongoing experiences in emergency departments and now you have been at the forefront of advocating for alternative hub like models for specialised mental health care in the community. And you are tied up very much with the advocacy and the modelling of that, the developments of models for that at the moment. Can you tell us your thinking about, picking up from John, developing real alternatives to just having everyone who needs more specialised assessment turn up in an emergency department?

Patrick McGorry:
Yeah ok. Thanks Ian. Do you want to unshare the screen – I probably don't need that. I'm not using slides so I can just talk. So, thanks for the opportunity to be part of this too. Yeah the pretty much first paper I wrote in psychiatry was based on a study we did of a whole cohort of young people coming into the psychiatric hospital system for their first experience of care… a bit like John was saying that the most obvious thing was that we were making them worse before we made them better. And we were able to assess them and follow them

up and we found that this was based on the clinical observation of a patient that I saw in a clinic, probably a few weeks or months after they had been admitted for the first time and they were having PTSD symptoms about their experience of treatment. It was a combination of the terrifying nature of the psychosis they had had but also the fact that they had been forcibly sedated, handcuffed by the police and thrown into a seclusion room. So, they were actually having nightmares and intrusive memories of these experiences. So, we measured that and we found that 45% of these first episode patients actually experience those problems. And that is happening to this very day. When people get shackled in emergency departments, when they get forcibly sedated and probably the focus is shifted from the psychiatric unit to the actual emergency department these days. With these large numbers of security guards surrounding them and intimidating them and all sorts of other things that happen to them. So, I couldn't agree more with Simon that's it's the wrong place for looking after people. All the efforts that you have been talking about tonight should prevent that from happening and making that an absolute last resort, are great. And what worries me a little bit about John's presentation is that it's still assuming that you have to be in the hospital, in the big palace of the hospital to actually start pushing things up stream. So, what we think should happen is that actually addressing this concept of the "missing middle", that's been very carefully mapped over the past few years. And it is basically an obvious thing that we've actually built systems of care that are doing better (still not perfect) about providing primary care access, so the first port of call is more accessible than it was say 20 or 30 years ago. Still obviously, it could be critiqued and not perfect and the state governments have actually have continued to do the super acute bit in a rapidly shrinking way, so much so that we now have a Royal Commission in Victoria that you referred to with the Premier describing the system as "broken". So, states have actually retreated if anything from their responsibilities. So, there is a huge hole, a huge moat in between and because there is nothing there for the more complex of persistent or more challenging problems, comorbid problems, they all end up as people seen in the emergency departments – and only when they have actually reached a point of crisis. There is a whole heap of untreated morbidity out there that hasn't reached the crisis yet, just sitting there like a big sink of misery and distress and suffering. So, what do we need to do? We need to build something in that middle. And what should it look like? And, I take the point that is there any genuine real reform in that? I mean some of the things we are trying to advocate for are really reprises of the 1990s. You know the mobile assertive treatment functions and those sorts of things. So, technology is obviously the main difference from those days and that obviously can augment and strengthen in ways that Jo-An showed in your modelling. And really improve the power and capacity. But we obviously need a very substantial growth in resources and we are not going to do anything by employing more coordinators and more peer workers to coordinate nothing. No I'm sorry, I think that is without a significant surge of investment - that sort of is what the government is saying at the moment – "all we need is more coordinators"… We don't need more coordinators, we need more people to do the actual work, and its complex work. And we need teams of people, we don't need individual providers doing that. So, what is the way to do that? Well, a focal point in the community, and this is what we advocated for before the 2019 budget and the Federal Government have endorsed a version of this. And this is a… in the youth area we could expand and build on the base that we already have that is the enhanced primary care model of headspace… we could build more back ending of that and we could enhance it with digital technologies as you have all been saying. But in the adult area, we have this problem – the GPs see the people, they can't get any next steps, they can't get to the next stage of care, I'm not going to say "stepped care" you will be pleased to hear. We are saying "staged care", so the next stage is missing, two or three stages are missing. So, can you collapse those into a more specialised, multi-modal, holistic sort of model including peer workers, including volunteers – that's another thing I've seen in

Europe. You know, large bodies of volunteers, not paid peer workers but young people in service actually really wanting to help and playing a role, so that's another untapped and reasonable resource to actually look at.

So, but we also need addiction specialists, we need psychiatrists, we need psychiatrists to stop practicing in isolated private practice mode and actually be part of teams – there needs to be incentivisation of that. We need quite a range of disciplines in these community focal points, and probably the right size of population is roughly equivalent to a federal electorate, I would say, surprisingly enough, that might be quite powerful and actually getting the thing funded.

So now there is federal government commitment to eight of these concepts. Now, it's still not clear whether the concept is going to be right. You know, there's been a Technical Advisory Group working on that and I think it's got an interest in some kind of shape, but there's a public consultation about to happen on that product. I can't really comment on it until it comes out publicly. But, you know, the sector and the general public and the consumers will get a chance to comment on what they think of that. I think there's a way to go before it gets to something really useful. But if that's something that was funded, was well funded and dragged in other funding streams, like MBS, NDIS and a whole range of other sort of, maybe state government resources too, you could actually see a way forward for something to sit behind the primary care structure, more accessible in the communitym more trusted, less stigmatised with a positive brand – of a welcoming and brand picking up what John was saying about the welcoming and you know, that the trust issue - that could be there and then if something like that was like a sponge to absorb that demand, then you could see a lot less traffic going to the ED and also could be a destination back from the ED, like what John was just saying. So there's a few missing structures and they can be also augmented by a number of connections now with telehealth and with digital health, which wouldn't have been possible back in the 1990s. But people are still important and actually skills and specialisations are important too. So, you know, I think doctors do have a role to play in and I think John should put it put a psychiatrist or two into his model, not just have peer workers and allied health.

John Mendoza:
Pat, it does have tele-psychiatry backup, so there's not enough money in the model to make it stretch to having them on site and I would argue they're not necessarily needed.

Ian Hickie:
These are ongoing issues. So I think on the on the positive side, the peer support is one aspect; the technology is a new asset that are expanding, I think Pat's argument is because in many of the ongoing complex situations, and I think in the models we have, at the heart of most the model we've done in this area and other areas are all more specialised care and ambulatory care settings. So if you ever entered the system, as David was discussing the start, you get into effective ongoing care systems.
Pat, I want to ask you about, and many people have asked you in the chat online, but where do you think the national advocacy is at? I mean, I've been accused of running around saying the sky is going to fall in and being alarmist and being…I am alarmed.

Patrick McGorry:
[Laughing] You're just a terrible scammer.
But, look, I just contrast, you know, I said to the trigger tonight in a private webinar, we've lost 103 people from COVID-19 thanks to the you know, the great efforts of the whole health

system and the country and all the rest of it. In the same period of time, we've lost 1000 people to suicide. So you know, are we going to make it the same effort in mental health that we that we have made in one health problem, which is life threatening and potentially serious. We've done a good job there. Are the lives not at the same value? So I think it's a rhetorical question. I don't know the answer to it. I really don't know. I mean, they indicated that it's a high priority for the government, you know that. But it's really, it's, does the money follow the rhetoric, does the reform appetite follow the rhetoric, and these are things that you and I and John and everybody else probably connected to the call have struggled with for quite a long period of time.

Ian Hickie:
Now, one of the things we're discussing tonight is, of course, for governments to see problems to be tractable, they have to see examples. So John's pursuing certain kinds of examples, you know, public sector in Adelaide, the ones you were talking about Pat in the youth area and the things Jo Robinson was talking about earlier.
One of the other ones that I've been particularly keen about is, I was struck in the COVID-19, the extent to which the Health Minister immediately went out and purchased capability in the private sector: ICU beds, ventilators, support, … brought to bear the national *[inaudible].*
So sitting next to me, as people would know, is Associate Professor Elizabeth Scott, who was a little bit late because she was actually taking care of people before she rushed to join us on the webinar here this evening, and has been responsible for setting up the Uspace service at St Vincent's Private Hospital, which St Vincent's invested in something that we didn't up until five or six years ago, we had no capacity to divert young people, in fact, away from our services where our public hospitals would not admit them. And now we've had some capacity to do that. Now, of course, that's only in the eastern suburbs of Sydney and only available in certain ways. For those who were interested, they could hear Liz talking to Geraldine Doogue on ABC's Saturday Extra, and I suggest you listen to the podcast because Liz, you were making the point that in your hospital, and elsewhere and somewhere else, that young people are being turned away, and other people are being turned away from care in the way that David was describing the outset.
So I want to ask you [Liz] about this engagement of others where things are really at, and as we see this increasing turning people away, which just creates the sort of churn that David was talking about, and particularly the failure to engage people with complex problems, the missing middle Pat was alluding to those with care on an ongoing basis. To what extent can we grab that capability in the private sector or grow it through further investment at this time of national crisis?

Liz Scott:
So thanks for that. So, I mean, the first thing I would say is that we have been overwhelmed by the demand on our service. So when Geraldine was asking me but is it new? Or is this what it how it has always been? And it certainly there is a new imperative, and certainly there are people obviously, who are now coming for care who didn't during COVID, but we see new presentations. So we have, we have now large numbers on our waiting list. We have large numbers waiting to see our community multidisciplinary care teams, and we are in the situation of having to turn people are away from care all the time. And these are people with you know, very serious long-term complex conditions such as the one that David is describing for his daughter, and I do not want to be in the same position as intensive care specialists in other parts of the world where I'm the person that has to decide who gets into care and who doesn't, [*inaudible*] and that is a sign of a system that has failed.
What we have seen with COVID is rapid mobilisation, the use of technology in practice, which has been dramatic, and also the mobilisation of health systems and buying capacity

from the private system. So we've had our private hospital that has been empty, waiting for COVID cases to arrive because the government has been able to do deals. We have the same opportunity to provide capacity within the private system, and the expertise that sits in the private system which is currently not being efficiently utilised. So we do have capacity and if we and I think there is an urgent need to do, to do the same thing that we've done with COVID – to really look at the resources and mobilise the system, to provide the type of care and intervention that people need to prevent some of the deaths of despair, that have been described overseas that are predicted by this modelling.

Ian Hickie:
So Liz, can I just ask that because one of the issues that Pat is raising, and I think this is an issue we have been fighting about and Sebastian Rosenberg has been pointing this out on the Q&A. We've been arguing about models of care and many aspects of private care at the moment, which is not really private, it's federally subsidised care to small businesses, actually is quite isolated, is quite separate. It's quite disconnected, much of the time from the National kind of effort. So the sort of models of care that you're talking about, and we've been talking with other insurers and private providers, is a different model of care to that which has traditionally been provided in the private sector in Australia.
So can you just tell us a bit more, Liz, about the other work that you've been doing with Mind Plasticity and other practices to transform what so called "private practices" to be something that actually delivers multidisciplinary, ongoing team based that Pat was talking about.

Liz Scott:
Yeah, so working within the resources that we have within the MBS framework, we have put together multidisciplinary teams based on our headspace model that have been able to provide some of the complex care and the ambulatory care that people need actually taking care to people's homes and providing care in those places. And obviously, the capacity to do that now with telehealth but really with digital enhancement with digital platforms that would allow us to stay connected with and track people over time, will really I think provide the innovation it will allow us to really provide capacity, where just doing more telehealth individual consults, does not really help with the scalability of the system, we really need to take things to the next level.

Ian Hickie:
So some of the other innovations people might not be aware of but also working with communities in a particular way. So I'm struck that a lot this work is in the Eastern Suburbs in Sydney, in particular the Jewish community, in the Eastern Suburbs Sydney – Rabbi Kastel is on a National Mental Health Commission, and have actually supported some of the housing support, some of the transitional support to particularly provide for families in crisis, for young people in crisis in those surrounding areas. So I think one of the issues for us, again, emphasised by some of Sebastian's questions and others, is there's other sets of factors, and I think John has commented, things that are affecting homelessness, things that are affecting families in crisis in Jo-An's model, things around domestic violence, and drug and alcohol use. You know, it would be interesting in Simon's comment, you need to know that people are going back into safe environments and that *[inaudible]* can use the point of crisis to actually often work with those other agencies to make sure that we are not discharging to no care or to a very unsafe situation. Simon, do you want to comment on, you know, we often need to take the opportunity of a crisis to work effectively with other partners.

Simon Judkins:
Oh, yeah, absolutely. And I think, you know, I remember it was actually a few weekends ago and I came in on a Sunday morning and patient have been cleared by the mental health team for discharge. And I went there to chat with them and they had a couple of tablets to take and the no clear discharge plan and he said, "Look, it doesn't matter all the counseling, and all the tablets, all the pills that you give me, if I'm discharging, and I live in the back of my car, my depression is not going to go away my anxiety is not going to go away, I'm still going to feel as though I'm living a life at risk."
So I think linking into other services, ensuring that we try and address you know, some of the social determinants of, sort of, healthcare outcomes when we try and actually put more effort into ensuring people are living in environments that are supportive, where they can access care, either pre-coming to the ED or post leaving the ED I think, you know, that's vitally important.

Ian Hickie:
So I think in the COVID-19 response, which is the kind of lens which we're looking at this through, and as John was alluding to, we're going to see more of that. We're going to see more of the fact that people have a combination of factors, whether it's job loss, family disruption, unstable housing. And it's often the case in a crisis is in a crisis there's often an opportunity to actually bring together so the challenges of that and whether we've been good at that in mental health. So I mean, I think many of us accept Pat McGorry's basic—and others' basic assumptions. Of course, we've been under-resourced, but we also need to behave differently in those partnerships and in different sets of areas. Now along the way, we've gone well over time and addressed a number of these particular issues that have been raised. I would just like to come back to David, who started and was kind enough to share his family's experiences at the start. David, are there comments that you would like to add or challenges that you'd like to leave us with before we try to continue with this work.

David S:
Thanks very much again. I've found a very, very interesting to listen to all the presentations, I have to say, and a lot of it—you know, I've listened to things and thought: wow, it would have been nice if, you know, if we'd had that. I did make a few notes and obviously as a parent, you know, the most important thing is the wellbeing of your children. So, you know, coming at it from that point of view, I have to say with this whole revolving door business of calling emergency services and my daughter going in and then being discharged, I have on occasion felt completely stumped. Completely stumped and desperate. And you think 'What next? Where do you go from here?' I have honestly contemplated and have made and am in the process of making enquiries about getting help overseas, you know, in a place where I've heard that there is effective mental health treatment. One of the things I think that has struck me about the way the system is structured is that it's all about waiting until some level of harm has arisen before the system will allow action to be taken, at which point it may be too late. From my point of view, it would be far better if the system was designed to prevent people from getting—to prevent people with mental health from getting to that stage. So particularly in terms of suicide and self-harm, I know one of the presentations mentioned that, you know, with my daughter's situation if she were to go into hospital, and she wasn't having suicide ideation, she's still having a very serious issue. So it would be nice if that were able to be dealt with. The point was also made about, about, you know, the way it's being done at the moment, especially through the ED being traumatizing. And that certainly has been the case with my daughter. Not only that, but she's lost faith in the system. And I think that impacts on her ability to open herself to getting this kind of help. And I suppose with all of this, one of the other things that I have made investigations about is ways around

the legal system, you know, are they—you know, especially because it's—my daughter's now 16, she gets to decide for herself, she's not really in a position to decide, um, very rationally what the best thing is for her, um, are there ways around it that I could take as a parent, and I've looked at those sorts of things, for example, applying for guardianship. I mean, I am a guardian in terms of age, but not for mental health issues. So that's one of the things I've looked at as well. So I just wanted to share those things with you, you know, from a parenting perspective.

Ian Hickie:
So David, I just can't help but be so struck that you're in a situation where you are seriously considering taking your daughter overseas. Australians have a belief that, you know, we have the world's best health system, we pat ourselves on the back continuously. And I'm continuously asked, "Well, where is it better?" And I'm afraid to say you're not the only parent that I know of, with a daughter or with a child with a complex problem, particularly an adolescent, that is actually thinking about, where are their alternatives? You know, and I think the reality is for Australians, we need to hear that. We need to, we need to think about it, we need to stop and dwell on that. And in the clinical leadership we have in our roles within our communities and the advocacy that we have, and those of us that have a voice in this particular discourse, we just really need to stop and hear that. If that's the situation we've reached, essentially pre-COVID, what will be the situation as COVID progresses on an ongoing basis? I hope that across the discussion tonight, people have heard about where there are innovations, they have heard where there is leadership. We do present the modelling not to scare people, but to show, continuously, where strategic investments would make a difference. I think what is underreported—and some of the public commentary I'm associated with, it shows the bad side—what our modelling shows is what can work effectively in combination and where there needs to be innovation and urgency. I guess my frustration is I still have a strong sense of real complacency. And that if we don't talk about what the situation actually is, governments, government responses and societal responses will be slow. We talked about more integration, more federal state. I think this involves every hospital, every emergency service in all of those places. I'm very grateful to people like Simon for the leadership that he's shown in those emergency departments to work with complex systems and to the other clinical leaders that we've had the pleasure tonight. But I'm particularly grateful to David, for sharing his family experiences with us. For those who are interested in receiving more information about resources that are out there, a slide will come up shortly showing other resource settings that we have. We have a series of other webinars that we have promoted in these particular areas about digital mental health, about flattening the curve and where we go. These webinars are possible due to the support we have through the NHMRC, through our Centre of Research Excellence, YOUTHe, but also to a number of other private and philanthropic supporters of this particular area. Some of the issues related to education we are pursuing very actively with our relevant staff. There are another range of people who are interested in finding solutions, and we're very grateful to them for their investments not just in youth mental health, but across the board. It is an ongoing dialogue. We hope to use these webinars in these formats. Some have asked about ongoing advocacy, I'd suggest that you get a hold of these webinars, discuss them, take them forward, distribute them widely. This will be an ongoing, and I hope, urgent discourse that we are all part of for the community in which we live. I recommend a podcast to you from Sydney Ideas from last week on the future mental wealth of Australia with Allan Fels and Geoff Gallop and others in terms of how we actually mobilize society more broadly in terms of economics and education. Within that, the health sector plays a key role, and hopefully in terms of our own work that will continue to be a focus of our NHMRC Centre of Research Excellence, our partnership with our colleagues such as Simon in the emergency

sector. We do look forward to particular ways forward, potentially from the Victorian Royal Commission, certainly from the Productivity Commission inquiry report due shortly, and really what is happening at a federal level. We have seen responses from the Federal Health Minister, there is a new Deputy Chief Medical Officer, Dr. Ruth Vine, as part of the Australian National Committee that is looking at these health threats. But I think we all need to be part of that discussion. On many, many future occasions, mental health has been discussed. I must say I'm old enough to know that there's a 25-year national strategy talking about integration of these issues. Now is the time for serious action. Thank you for your participation this evening. And thank you to those who have joined with us in this discussion. Good evening.