TRANSCRIPT

Sydney Ideas podcast: Flip the clinic

The digital approach to mental health support

Wednesday 8 April, 2020

NORMAN SWAN:

Hi, welcome everybody, my name is Norman Swan, to 'Flip the Clinic', this meeting which where we're trying to discuss some new ways of thinking about distance or tele-psychology, tele-psychiatry in the New World, new models of care.

We're not going to be talking about new ways of billing, what we are going to be talking about is how we actually might transform mental healthcare in Australia.

And it's really quite a radical moment in Australia, where within a matter of weeks, days, in fact, we've transformed how care can be delivered. The sort of things we've been talking about for a long time. And it's now on threshold. No, it's now happening. And, and really, this discussion we're having is independent of platforms. It's about and it's about actually how to do the job that we're all trained to do.

My name is Norman Swan, I produce and present the *Health Report* on Radio National and I'm hosting this. Ian, let's start off. Can you tell us some context to this discussion around Flip the Clinic?

IAN HICKIE:

Yes, so I'd like to thank people for taking the time. And I'd like to recognise the Indigenous people of our lands and the lands on which we all meet and are collected today and pay my respects to their elders past and present, and to everyone who's living with mental health experiences in their own life and in their families.

This is such an interesting time and challenging time for all of us. And we have seen in the Australian healthcare system, the sudden discovery of Alexander Graham Bell's invention from 1876, the telephone, this week in our own Medicare system, and suddenly everyone is having to use it to connect the people in need of a service. But actually, digital mental health isn't simply tele-mental health.

It's not really about telephones, it's about the 21st century digital technologies that we have and the capability, the potential, that we might find in Australia and internationally, to do what we've always wanted to do: actually take services to scale to meet the enormous need that's out there, in quality mechanisms, and in a highly personalised way.

We've been very lucky in Australia, and we'll hear from an international expert on this shortly, to actually have a great deal of innovation here. But much of that innovation has never reached, actually, those in greatest needs. It's been in universities, it's been in particular platforms, it's in particular centres, but it's never really impacted on the wider health centre.

So this is the first in what we hope is a series of webinars that will actually go to what are the big issues, if we're finally going to go to scale and provide a wealth of opportunity for those who have mental health issues to access world's best care in highly personalised ways in ways they may prefer, that at the end of the day, we might end up with digitally-enabled services that are actually considerably better and scalable and accountable and transparent

and fundable, lots of aspirations, but to do that, we need the wide range of perspectives that are here this evening.

To give you some idea what I'm talking about in terms of the capabilities here. I wonder if you could just bring up the one slide, my first slide here for people to see, when we talk about flipping the clinic, what we're really saying is that there are a whole lot of services out there at the moment, what you might call the retail end.

All the brands that you would recognise in Australia, of many different ways that people come in historically through our clinics.

If people start to come in digitally through those clinics and combine information across all those services—so the big football shape or sausage-shaped operator here—we have platforms, we have technologies that can integrate those informations across those different platforms so we can work in a multidisciplinary way no matter what service you come in for, to meet your needs.

And down the bottom we have all of the other world of the internet, of its tools, of its apps, of its applications, of its personal tracking devices, of its social groups, of its social connecting functions, which may be made available to users of all those sets of services that we currently recognise.

If I go to the next slide, [I'm] personally associated with one of those platforms now as the InnoWell platform.

But what I wanted to show you in that is that built into those types of platforms is, as you'll see on the right, the idea of a video interface, and that's what everyone's suddenly discovered.

This is a very famous child psychiatrist colleague of ours, Laura Ospina-Pinillos in Colombia, who was providing services while she's sitting in Bogotá, to people in Broken Hill, in New South Wales, using these types of platforms.

But it's that video capability embedded within a whole digital system. So when we talk digital mental health, we're not just talking what's happened this week, of suddenly using video or telephone. We're talking about systems that take the best of what clinicians currently do, that interface, that capability, but potentially taking it to scale with all sorts of new capabilities.

The rest of the people you hear from tonight are all engaged in various ways of many of the issues—who's it for, what populations, how is it safe, how will it be regulated, how can it be optimally done? We hope to use the opportunity with you and with your comments, and we have had more than 800 people register for this particular webinar, we want to hear your comments, we want to hear your key concerns.

We want to hear what fusses you so in the future, we can plan further information on interactive sessions that help us as a community come to terms with the tremendous opportunity that now arises from otherwise what has been one of the most challenging times in our social history with the COVID-19 crisis. But out of that is an opportunity, potentially, to

do things really differently. Take the academic, take what they develop, take the narrow, and see whether we can apply it at scale. So at that point, I'll hand back to Norman.

NORMAN SWAN:

Yeah, I mean, it's fine to say all that, Ian, but I mean, it sounds so abstract. I mean, we're talking about a different session, for example, with a client and you would face-to-face—is there, is there, is this more like single-session therapy or is it, you know, what's the nature of the interaction and are we changing that fundamental model?

IAN HICKIE:

There's no doubt that digital health interventions are fundamentally different than in-person, one-to-one in particular, in-clinic with a warm, caring, lovely therapist-type person.

Mental health is filled with warm, lovely—not me—but it's filled with other warm, cuddly, nice, interactive people. And people love that.

What it's often not attached to, though, is specific skills, training, tracking, triaging, making sure you get the right care first time in ways that actually suit you. It's quite, in many ways, profession-centric and clinic-centric and not scalable. So clinicians, fundamentally, do have to take the best of what they've already learned, apply it differently, but then combine it with a whole lot of new technologies and skills that typically they have not used, and potentially do that with many, many more people than they currently do.

So yes, you won't be simply taking the existing item numbers or the existing clinical training in psychology or psychiatry or general practice or social work or nursing and just doing it over a video platform. That isn't digital mental health, that's telehealth just using a more recent invention than the telephone.

So yes, it'll be fundamentally different. You'll still need the skills that you had in your discipline.

But you're going to need to learn to interact with technologies in greater partnerships with people in care, where they are actually partners in care and empowered by the technologies in ways that I would argue is not the case with current interactions.

NORMAN SWAN:

Is this about tracking, surveillance, monitoring? I mean, what's it about?

IAN HICKIE:

It's about personalisation through monitoring. Everything in the world we talk about is consented to, is approved by the person themselves, but they get to put information in.

They get access to tracking tools, whether it's sleep wake cycle, whether their mood monitoring, whether their substance abuse monitoring, whether other physiological monitors. They learn more about themselves.

So the whole clinical thing is not averages, not clinical trials, not clinical guidelines, not what on average works, but actually what works for you.

In what way does exercise drive your mood? In what way does reducing alcohol improve your sleep? In what way does changing your thoughts change your sense of wellbeing?

It becomes about you over time, so the tracking, the measurement-based care concept over time, does become critical.

NORMAN SAWN:

And what about the client population? Is it all high-prevalence problems, anxiety, depression? Or can you, do you envisage low-prevalence disorders, people with psychosis, bipolar disorder and so on being helped by this?

IAN HICKIE:

I think one of the things that will be really different here in the multi-dimensional assessments that I'm using in our systems is we will respond to complexity much better. Not to diagnoses, not to any categories, not to low prevalence versus high prevalence, but to complexity.

What is your sets of needs? What are the services you actually require to work in partnership? Who are the multidisciplinary care providers? And how do we contact you and, as we'll see in John's data shortly, much more information from the service user, much more regularly, to drive a much more responsive service system.

NORMAN SWAN:

Okay, well let's move to John Torous, who is the Director of the Digital Psychiatry Division, Department of Psychiatry, at Beth Israel at Harvard Medical School in Boston. He's got up at some totally ungodly hour to do this. So, hats off to John Torous.

John, just tell us about your experience and again, give us the touch and feel of what we're talking about here.

JOHN TOROUS:

Yes, so thank you guys for having me. I think Australia is a world leader in digital health and especially digital mental health. So it's an honour to be beaming in, even from Harvard, talking to all of you about digital mental health.

And what I wanted to show you guys was in a couple slides, some examples that are tangible things of how digital mental health can be different, in some ways, offering the same type of information and services. So I'm gonna flip to the next slide.

So here's just an example from actually, really 2014, now six years ago, and this was a simple smartphone app where we asked people [with] depression to basically take surveys about their mood every day. And I think what's interesting is, here's what that actually looks like in reality.

Those green boxes are when we saw the person in the clinic on day zero and 30. You say, what is that blue line that's kind of like a stock ticker graph?

That's people's daily mood. It goes up and down compared to the green boxes. And you notice two things. It's higher than we see on the green boxes and there's those diamonds when someone reported thoughts of suicide or self-harm that were severe.

So you're seeing just by asking people surveys in real time, when they come back for a clinical visit, having a graph like this tells a very different story than again, say, having two of those green boxes.

We're understanding people's dynamic symptoms, how they evolve over time, how there's fluctuation, and again, that's just by asking people to give us data in real time that we can use for their care and we, the field's been doing this for a long time, and we'll jump to the next slide.

NORMAN SWAN:

Just before we go to the next slide, um, there are apps everywhere, John, with all due respect. And one of the problems is that they don't necessarily integrate with anything. They just sit there as an app. And the therapist doesn't actually use it. Because there's work and time involved in integrating that into their system.

So it's all great, you've got a mood thing, you can look at it. But in fact, you don't use it because it's time-consuming.

JOHN TOROUS:

Yep. So there are a lot of apps. We think there may be, when you kind of count the meditation, the mindfulness, the wellness, over 10,000 mental health rated smartphone apps out there today.

One of the projects we do here in the States is I chair the American Psychiatric Association's Health IT Committee.

We actually have an app evaluation kind of work group and task force. And we've kind of looked at how do you separate out the good from the bad apps? How do you kind of have some guidance to find a useful safe tool and avoid some of those dangerous creepy ones?

And what we've kind of found is one of the first things is to think about safety and privacy, as you mentioned, Norman, earlier, kind of making sure that ethics are taken care of. But I think equally important is looking at the clinical integration.

If you can use this tool, can you access your own data? Can you share it with someone? Can it be actionable? If you're tracking your mood, you want to be tracking your mood towards the goal of something, either towards self-help, self-care, or sharing it with a therapist and integrating that data.

And if the app can't do that, it's probably not gonna be a good tool. So I think your point is well taken, we may draft you into our task force, the American Psychiatric Association.

NORMAN SWAN:

That's all I need. Sorry, I interrupted, you go into an excellent—

JOHN TOROUS:

Oh it's okay. Yeah. So we'll jump back to the next slide. So we talked about how from asking surveys, or as it's kind of known, technically, as ecological momentary assessment.

There's also this idea of digital phenotyping that we can gather a lot more data than just surveys from the phone.

And this is an example of data we can get from digital phenotyping where we can clearly get surveys, we can have, we can get environmental data that people may tag for us from their phones, the phone certainly knows where I am right now—it knows where you are, Norman—we can certainly get that data over time.

And you can see how we can anonymise it. We can just get a heat map for one person, of where they were on one day being a column, you kind of see weeks.

So we can learn about time at home, distances travelled. We can learn about step count, exercise and sleep. And we can put all this data together to learn, in this case, about, we're learning about relapse and people with schizophrenia.

So what we did is for each person, we set a personal baseline, you can see in that kind of graph all the dots, then each day once we knew where someone's personal baseline was, we said well, is that person's mobility, is their sociability and their self-reported outcomes or surveys, is that kind of below their baseline or is that above it?

And what we could tell is when we had a lot of dots above their baseline, for each individual person, for one person, this is, we say you know that person is at higher risk.

The red arrows come when the person relapses and have to go to an emergency department. But you can see that because we can learn of each person, what are their personal patterns of behaviour related to their illness, we can kind of say, well, certain things are happening together in one person compared to themselves, that may indicate that there's higher risk.

So kind of using digital phenotyping, gathering more data from the phone, we can learn about kind of personal risk patterns for each person. And I'll explain how we put this together on the next slide.

So how we use this in Boston is in research, but also what we call a digital clinic.

And you can see that because an app and again, many apps can do this, there's so many, as you kind of said, great apps from Australia and interesting work, but if we can collect this physical activity, environmental stress or real-time surveys through an app, kind of yellow in that box, we can run relapse risk algorithms. But we can also kind of make a personal plan for people, as Dr. Hickie alluded to.

We can learn about how people are doing. But that doesn't come between below the patient and clinician.

We want to ensure it's a strong therapeutic alliance and that additional digital data, if anything, should be bringing the clinician and the patient closer together. It helps me when I do this to understand the lived experience of the people I'm working with, what they're going through, and in part to make sure this doesn't detract from the clinical visit or quality, what we've also done here in Boston is we've added a new person to our clinic called a digital navigator.

If you think about it in radiology, it may not be the radiologist who actually takes the X-ray, it may be a technologist, right, a radiology tech. In pathology it would maybe be a pathology tech. So if you think about it for digital psychiatry it may have a new person in the care team, a digital navigator.

And what that digital navigator can do is they can help set up apps, they can help troubleshoot technology, they can help with pesky webinars getting those video things going. So I think really thinking about new tools and new data and new people to support it.

That brings me to the last slide. I was thinking about making sure we support people with the right education, the right skills and knowledge.

We also have to make sure and realise that not every person—clinicians but patients as well—has been given the kind of opportunity to learn how to use technology towards their mental health and wellbeing.

There's a programme we have called DOORS—Digital Opportunities for Outcomes Recovery Service—we actually offer groups where we teach people, especially with schizophrenia and bipolar disorder, what is a smartphone?

They may have one, their social worker may have given them one, their therapist may have helped them get one, but no one's actually said how do you actually use this phone towards your mental health and wellness?

And you can imagine that people really want to learn. Sometimes when you are given a phone you don't get the manual of how to use it to improve your mental health. So making sure we offer training programmes to help people best utilise technology, again, clinicians and people with lived experience of mental illness as well, can be a very powerful tool. So I think you're seeing it's new data, but it's also new systems of care, new team members and new education as well.

NORMAN SWAN:

And, the, sorry I just want to back up a little bit. Well, so for example, let's say you've got somebody with schizophrenia or bipolar disorder. This looks too good to be true. I mean, you offer something like this to somebody with schizophrenia, if they've got a sort of slightly paranoid, paranoid mood.

They're just going to think that you're following them and they wouldn't trust it and they're going to throw it in the bin. How, what sort of acceptability do you get to convince people—and that's exactly what you are doing. You're following them. You're monitoring them, to help them or be it, but it could feed delusional paranoia for example.

JOHN TOROUS:

So it's a good question to consider. Do people with schizophrenia or psychosis, who may at times have symptoms related to paranoia, do they worry about technology like this? And the answer actually is no. If you think about it, there's nothing about having a mental illness that means you don't want to use technology, you don't want to use a phone, you don't want to connect to the Internet.

And certainly, I think, when you realise that this data is being used with your consent, for you to understand your mental health, for you to get better care, for you to avoid relapse, I think you're seeing technology, if anything, sometimes people with psychosis or, again, schizophrenia may spend more time online, they may be more socially isolated, right, using these tools.

And finally, their therapist or clinician or psychologist, psychiatrist says, “I want to work with the same tools that you're using, I want to use the data that you're sharing on Facebook

already. You've probably given to a lot of sources that aren't actually protecting your information. I want to use this to help you."

We've had very positive responses in Boston. Clearly there are gonna be some people who don't want to use video visits or apps or technology. There's actually a very small minority. If you look at the medical literature and say, do things like this make people paranoid, do they kind of become worse for it? The answer is actually no. And there's research from Australia, or around the world.

Maybe afterwards with Dr. Hickie we can post some of this research and kind of say, look, people actually feel that, someone actually wants to understand your lived experience of the illness. If anything it's quite the opposite sometimes, or most of the time.

NORMAN SWAN:

And then the right, the right time to introduce this digital approach to care and a new model of care, when somebody regardless of whether it's schizophrenia, bipolar disorder, or commoner problems such as depression and anxiety, people can be acutely unwell. And can you introduce them when you're acutely unwell, or there's a right moment, or the right moment is day one on the first consultation.

JOHN TOROUS:

So the right moment is on day one, again, first a digital technology, one of the weakness is we don't have a baseline. We're learning about it in comparison to each person. We have some ideas, but because it's newer, for these digital signals I talked about, we really do a lot of within-person comparison, meaning we look at changes within each person. So having it starting on day one gives us a better baseline of how someone is doing and those changes.

NORMAN SWAN:

And there's going to be a lot of competition in the marketplace between platforms, just very briefly before we move on. Is the extent to which the, um, is the criteria you would use as a mental health professional for selecting the platform for you.

JOHN TOROUS:

So the criteria that we've worked with the American Psychiatric Association is four steps, it says find one that's safe and private. Find one that has evidence that it's effective. Find one that's usable, it has high usability, and fourth, find one that can be well, easily, clinically

integrated. So what's safe, what's effective, what's usable, and what can be well clinically integrated. And those are pretty universal criteria, but you'd be surprised how quickly some of these apps don't meet those bars.

NORMAN SWAN:

Okay John, thanks very much. We'll come back to you later, no doubt, in question and answer time.

Sam Hockey is next. Sam is Youth Ambassador, Youth Mental Health Ambassador, former Mental Health Commissioner, grew up in New South Wales coast and has lived experience in this area.

Sam, do you want to just talk to us about your perspective here in terms of design, co-design involvement of consumers in this?

SAM HOCKEY:

Yeah, um, I think that it is an incredibly, incredibly poignant time to be using this space of not just tele-health, but digital health, and flipping the clinic as the webinar is called, and using, particularly using co-designed products—products that are, and services that are designed with the user at the centre, ones that model the delivery of care with the clinician and the individual together, ones that have had either the individual as part of the design process either in co-design or as consultation.

Either or is fine, but letting the public know which you have used is extremely important, especially to people with lived experience. And then I think that, I think doing that is the only true way of being able to actually have a product that serves the individual that you're trying to serve properly and truly.

NORMAN SWAN:

So tell me, you've experienced this concept of ‘flip the clinic’ yourself in terms of digital mental health?

SAM HOCKEY:

Yeah, yeah, and I personally have found it incredible. I found it, er…

NORMAN SWAN:

What can you share about it that you would like, you know, I think it's important that we get a feel of what it's like as a consumer at your end.

SAM HOCKEY:

Yeah. I think, first and foremost, it's not to replace face-to-face services. That is not at all the idea. The idea is to complement and to further build the pathways between the individual and their clinician, and the service provider.

I have used anything from Fitbits to my Apple Watch, to sort of sleep monitors to track how my personal progress is going and those sorts of simple circadian rhythm-style aspects actually have affected my mental health and wellbeing.

And similarly, even just using face-to-face and sort of FaceTime, Zoom conferencing, for appointments, especially recently in this time, I've had an appointment over FaceTime so that.

NORMAN SWAN:

So how did, how do you feel about the effectiveness of, sort of. So there's personal monitoring, the personalisation that both Ian and John have spoken about, to suit your needs in monitoring your own health and wellbeing, to give you control, understand all that, but tell me about the therapeutic efficacy, if you like, from your point of view as a consumer when you're doing a FaceTime session on your mobile phone, or are you doing it on your laptop?

SAM HOCKEY:

Yeah, I think that it hasn't, again, it doesn't replace face-to-face, there is a percentage that lacks with face-to-face, or isn't as good as face-to-face, but the thing is, you are still receiving the care when it is the appointments, and it isn't replacing or ignoring all of the face-to-face appointments, it's to do every other appointment, or, in times like now, to actually be able to attend those appointments and for me personally that's been an absolute lifesaver, particularly in such a crisis.

NORMAN SWAN:

Could you see, um, I mean you work in peer support, don't you?

SAM HOCKEY:

Yes, yeah.

NORMAN SWAN:

Could you see it replacing for people who prefer it? Would you see any detriment, if you like, in their care, if people opted for this as their mode of care for everything? You know, almost no face-to-face?

SAM HOCKEY:

Yeah, I mean, I guess I could, um, for certain individuals, I think I could. I know a lot of people who tend to use only online resources like forums and chat groups and a lot of people prefer the anonymity.

And so there is that, that benefit of it. However, I think that the true beauty of it is used in conjunction with face-to-face and that's, that's something that you can't miss out on.

NORMAN SWAN:

What's your message for the psychologists and psychiatrists, social workers, et cetera—et cetera is the wrong word—watching—your support people as well—watching? What's your message?

SAM HOCKEY:

I think the core message is to include the individuals, the consumers, the carers, and those who are supporting the individual in the building of a service, if you're building a service, or in the supporting of the service and delivering the service.

Particularly at the moment it's changed completely, it's no longer as simple as turning up for an appointment and being able to register so many things. I mean, we only see a portion of the body at the moment.

So being able to rely on those other communities and services that we can actually see, you know, whether they are going for walks, how they are doing with sleeping, how they are

doing with their social interacting, to actually get a fuller picture of an individual and how they are in their wellbeing.

NORMAN SWAN:

Sam, thanks for talking about that and we will no doubt come back to you later in the webinar.

Professor Frances Kay-Lambkin is acting Pro Vice-Chancellor in Research and Innovation and DVC in Research and Innovation at University of Newcastle, eminent researcher and psychologist, extensive experience in clinical research, particularly in complex and comorbid mental health issues.

What's the perspective that you come from here in terms of this new way of thinking about the clinic and mental health care?

FRANCES KAY-LAMBKIN:

Thanks, Norman. And I think it's really important that we're doing this this session tonight, so thank you, everyone for making time to tune in.

The main exciting part for me is still mental health really does bring brand new capability and new capacity to us in responding to the mental health problems in our community.

So I'm sure we've heard all the statistics about typically in Australia, we don't get great uptake of the mental health treatments in our mental health and drug and alcohol services. So it's only around a third of people who will seek treatment in any one year.

And what our research at the University of Newcastle and also through the Matilda Centre at Sydney University has indicated is that through these digital mental health tools, we're able to connect with people in our community who we've never, or our services have never, connected with before.

And that's not because they're not severe enough, if that's the way to describe it, severe enough in their concerns to warrant treatment. It's actually that often people haven't known how to, where to, or whether they've wanted to go to those formal services for help.

So what digital mental health does is really take care out of the services and puts it into the hands of people who need help when they need it.

And I [unintelligible due to lag] in that way transformed the way we think about mental health treatment and that genuine flipping of the clinic and it's putting that person themselves at the centre of it all. And I think the exciting thing about this is that it's also an extremely effective way to deliver and connect people to high quality mental health treatment.

And again, our research and others around—the Brady Bunches, I'm looking at us all today—really does show that that digital mental health tools are, and can be, as effective as face-to-face counselling for conditions like depression and anxiety, also now for psychotic disorders like we've touched on, and particularly for, and can be actually more effective for, things like alcohol use disorders, cannabis use disorders and other substance use disorders.

And also the complexities, or the extra issues that comorbidity—so all of these issues occurring together—can bring.

And just picking up on a couple of the points that Sam was mentioning, people in our trials who've been through our digital programmes actually rate their therapeutic alliance, so their experience of therapy in terms of the bond and their connection to the therapeutic process, equally as high whether they're receiving a face-to-face treatment or one of our digital programmes.

And for digital tools, they really rate their independence and self-efficacy higher and that's associated with better outcomes for people who are higher on self-efficacy.

So I think what also excites me about digital mental health is that it's bringing a new level of quality to mental health care, and is enabling an ongoing connection to that care in a way that will make a genuine difference right now for people, but also over the longer term as they can dip back into, and out of, these digital tools.

NORMAN SWAN:

I'm not sure Frances, how you get better quality out of this. I mean, I spoke about the potential nervous reaction or see somebody who might have schizophrenia to be monitored by something like this. And John answered that question.

But I would see also a nervous reaction on the part of maybe a therapist who are psychologists or psychiatrists who says, Oh, this is a way of monitoring my quality of care, and I'm not going to help you.

They're going to be monitoring my fidelity to CBT. And I like my freedom and be able to do whatever I like. So I'm not quite sure how it translates to quality.

FRANCES KAY-LAMBKIN:

Well, I think it's in a really it's actually in the model and the way we deliver the care and so the, the automation or the programme or the course that we might develop involves some education and some ways in which a person can teach or train themselves to do things like problem solving skills, or identify and challenge and manage problematic thoughts.

And they those things and those aspects of, for example, cognitive behaviour therapy and mindfulness and those sorts of skills are very easy and straightforward to transform and

deliver via digital programme much like a course that many of us are completing now at home, in an online way.

Or we're teaching ourselves to learn certain behaviours and concepts. And but there's stuff that you actually can't delegate or assigned to a digital tool, in that way, sense comment about always dealing a question or a therapist to work alongside these tools is important. And that's the model we want.

We want to free up the clinicians to be able to deliver those aspects of care that we can't automate, and that we can't teach people to do themselves, that they can be much more responsive and probably, I guess they're much better equipped to deal with those sorts of situations and issues, but we let the digital tool actually deliver that that consistent high quality level of education and training, the person needs to do those extra things that, that the therapist doesn't always need to be the one to deliver.

NORMAN SWAN:

Got to be connecting with people in the workplace before we've got a door in which to enter it in order to connect. So I'm not quite sure how you're connecting to be we've never connected before.

FRANCES KAY-LAMBKIN:

It's in a number of really interesting ways. It's there through forum for like this. People are on Facebook, they're searching for these sorts of tools, we might go out and make, you know, on social media.

NORMAN SWAN:

Usually hunting for clients to you?

FRANCES KAY-LAMBKIN:

That sounds really creepy when you put it that way. Yeah. But it's actually using the same kind of digital marketing and other tools that a lot of companies can use to promote the value and the quality of a product.

But I guess the message is that we don't wait for people to try not to wait for you to come and find us.

And I think that's what one of the messages is needs to be is that we actually need to be going out there and proactively promoting. This is a viable credible and it important service that can augment our health and wellbeing.

NORMAN SWAN:

Thanks Frances.

Julie Sturgess is chief executive officer of the north coast of New South Wales Primary Health Network.

And as such is trying to develop new models of mental health care on the north coast of New South Wales. In fact giving health services to cash out their mental health services as well as the PHN and develop new styles of care.

Julie, what are you finding in this new model? On the north coast?

JULIE STURGESS:

Look, I would agree with what everyone said. I think the opportunities that we found in trying to push the digital agenda, you know, they've been met with enthusiasm and, and a lot of optimism, really and, you know, I think what drove us in the first instance and to really investigate where we could go with this was that, you know, we're talking about telehealth this week in the in the context of COVID.

But really long before this, you know, access to appropriate mental health services, particularly on the north coast was a really big dilemma for us.

And certainly when we look at our community, you know, we think probably across the demand in our community for mental health services, we might meet about 20% of that.

So the, the onus on us was really to investigate ways that we could actually deliver better outcomes and more efficient services in mental health to people on the north coast.

And so, you know, similar to Frances's comment, you know, what we had to look at really closely was, how can we look for alternative models to deliver the things that are appropriately delivered via digital context.

And so then use those very scarce resources like clinicians. And you know, that's something that is particularly relevant in our regional and rural context to be delivering either via face to face or via telecommunication channels to video or telephone to augment those things.

So I think it's been incredibly important for us to try and, and look at, look at that. And I think the opportunities that we saw, were, you know, there were some surveys done across the

country that looked at people's use of particularly mobile home and mobile phones and digital technologies.

And I think even in Aboriginal communities identified that about 98% of people have a mobile phone that they actually use now.

I mean, we probably realised very recently that connectivity still might be an issue with that and we're augmenting that and then access to data is another thing that we need to also support but in general people there, there is a very widespread availability of mobile technology to take up digital solutions.

And I think also to Frances's point, you know, what we know is that a lot of people are not accessing those early and exposing themselves to those best opportunities for recovery.

So some of the things we are doing is exactly as she highlighted, using social media, Twitter, Facebook, Instagram, and really trying to understand the needs of the community through those mechanisms, so that we can tailor our responses and encourage those people to seek care.

So lots of opportunities and then in seeking that and understanding those needs, particularly the work we're doing around introducing really clear assessment and staging tools so that the services we provide are tailored to what people need rather than the traditional services, then have always been delivered.

NORMAN SWAN:

And I think you've had some benefit in terms of do not attend?

JULIE STURGESS:

Look, most recently in the last few weeks, obviously there's been a really market shift to, to telehealth services for psychology support and particularly in the youth cohort.

You know, Jason can comment on this, but failure to attend rates are often, you know, around 25% to 20%.

And what we've seen is just a dramatic reduction down into very low single digit percentages, you know, and we're assuming it's because the ability to access those appointments is just so much easier for people.

NORMAN SWAN:

Thanks, Julie. But we're going to do Peggy Brown now. She is senior clinical advisor, the state of Michigan for safety quality in health care, and has numerous leadership roles within the male health sector in Australia and particularly consultations around the national safety quality of digital mental health standards.

What are we talking about here we'll be talking about digital mental health standards Peggy?

PEGGY BROWN:

Well Norman, the Australian Government Department of Health has commissioned the Commission on safety and quality to develop these digital standards.

And we're talking about standards that cover telephone and video conferencing, web-based services, SMS and apps across mental health, suicide prevention and drug and alcohol sectors, and different categories of services as well.

So Information Services, digital counselling, treatment services, and peer to peer support services.

NORMAN SWAN:

And the elements of the standards that you're talking about?

PEGGY BROWN:

We've done an extensive consultation process. And what we heard from that is that people really want to see standards in this space and they were both clinical and technical elements that were important to people.

And so at the moment, we're consulting on draft standards, and we have three standards.

The first one is a governance standard, and it integrates clinical governance and technical governance.

The second standard is around partnering with consumers. And we've already heard some of the speakers tonight emphasising how important that is.

And then the third one is around the model of care standard about establishing and delivering that the model of care about minimising harm and also looking at communication and recognising and responding to acute deterioration.

NORMAN SWAN:

Is there a standard that will prevent digital mental health going the way of non-digital mental health which is that we have drug and alcohol services separate from mental health services separate from suicide prevention, they don't talk to each other.

They don't like each other very much and comorbidity falls through the cracks. How do we? Are you going to create standards which force integration?

PEGGY BROWN:

Ah Norman, I'm not sure that we can achieve miracles. But certainly the emphasis...

NORMAN SWAN:

But you could make it worse with the apps, you could cement the problems in the system through the app.

So drug and alcohol, people will produce their drug and alcohol apps and services, mental health people do theirs. And the client will be the person yet again, who suffers?

PEGGY BROWN:

Yeah, I guess what I'm what I was wanting to say, I guess is that we're not trying to get within these voluntary standards to actually require or mandate that there has to be interoperability.

We are emphasising, I guess the person centred nature of the care and the need to actually look at what are the needs of the individual and how they can be best met and particularly with the partnering with consumers standard that covers partnering with the person in their own care and then partnering with consumers in the governance, the design, the planning of services and indeed in the measurement and evaluation of services.

So the emphasis on consumers at the centre I think will help with that, that what you're talking about, which is the kind of integration of all of the care needs across the different sectors.

NORMAN SWAN:

Thanks very much, Peggy. Is Pat Dudgeon with us?

Pat is with the School of Indigenous Studies and project leader of the ARC discovery indigenous right at the University of Western Australia and has been on the Mental Health Commission and various senior mental health positions within Australia and, and makes living contributions to indigenous psychology in higher education.

How do indigenous populations fit into this, this ecosystem if you like?

PAT DUDGEON:

Oh, look, I think I personally would have thought that face to face was more important. But you know, we subscribe to a concept of mental health which is about social emotional wellbeing.

So it is very much a face to face knowing your client's background culture, knowing what the you know, life priorities are, which can be different to mainstream and I personally would have thought that digi-mental health might have been a bit limited.

However, we've been talking to Lifeline and other organisations like that and they were doing the Crisis Text they were trialling that out before the pandemic came out, came down and they said that the greatest take up of that was young, indigenous peoples. So that was a bit of a surprise.

So I think we need to, you know, go back and especially with the Coronavirus in place you know that we know already some of our indigenous counsellors are using tele mental health, doing phone counselling, but it would be interesting to do some consumer surveys with indigenous Aboriginal Torres Strait Islander populations and see about the take up, I was interested to hear the lady from the PHN, I'm looking I can't see her face.

She said that the people she was working with in her area were very keen for Digihealth so I would open the door on it. I think we don't have much option now. So I think the luxury of choice might not be ours in anycase.

But for a lot of people who are living in remote areas they might choose not to access a counsellor in town or they're in their communities because of the shame factor or whatever. This might be a good way forward. And I think, certainly with the youth, it might be a good way forward.

But all of we've actually got a meeting with indigenous Psych's tomorrow night. So I'm going to share some of this with them. So I'm optimistic, cautiously optimistic.

NORMAN SWAN:

Mike Millard is clinical director of the clinical research unit for anxiety, depression, and St Vincent's Hospital. He's also director of THIS WAY UP, which is a leading evidence based provider of digital mental health and well being services who's actually doing it.

So you've got a platform that people can access now, what are the key messages that you think are relevant here?

MIKE MILLARD:

So I mean, there's been a lot of things that have been raised so far.

I guess I'd comment on I think that one of the things that we're mindful and I mean, I say this as part of the Clinical Research unit, you know is that when we're jumping into the sea of online tools to try to make sure we're using the ones that have evidence, one of the things that one of the reasons why people choose THIS WAY UP is that our stuff has gone through 34 randomised control trials, some of which have been replicated internationally.

And I mean, it was interesting to hear what John was saying over to Harvard, because they've been using our depression programme as part of their online service.

So the other thing that I would say is that I'm a clinician, and I've been using these digital interventions for many years in the flipped clinic.

So I use them to teach the patients the skills that we know work, and then I use my clinical time to help them to apply them. And I think that sits very well with the sort of flipped classroom model.

So I mean, on the slide that I've put together, I've said that there's a whole variety of the ways that we use our stuff.

So it's either as a standalone intervention and as a standalone intervention in practice on how it works. So that's for the high prevalence disorders. It's for anxiety for depression. It's also for a chronic pain course as well.

I've talked a little bit about augmented face to face therapy or telehealth as we're talking about. So I get people to do the lessons in between each of the sessions.

And then that's the structure that I use when I'm applying stuff and helping the person to apply the skills. Because we all know that with things like Cognitive Behavioural Therapy, the skills are simple. It's the application that actually hard.

The other way that we use this I mean, for our clinic, we're an anxiety disorders clinic that used to have a very, very long waiting list. Since we've introduced the online CBT, we don't have a waiting list. We get people straight up to do it.

It introduces people to the concepts and principles and then a lot of people say that's enough. Which is a really interesting, I think development

NORMAN SWAN.

Thanks very much.

John Mendoza is director of ConNetica, several executive employments, including the inaugural Chair of the Australian Government's National Advisory Council on mental health and works hard as director of ConNeticaand better futures for individuals and communities across Australia in various areas of mental health is in Adelaide.

What you're connecting with people in high need, what's particularly happening in Adelaide, John?

JOHN MENDOZA:

Well, Norman, you'll be might be surprised to hear lots is happening at life. The thing we're doing at the moment and it's part driven by the COVID-19 problems that we are all confronting in terms of how do we continue to provide care to those people with persistent and sometimes severe mental health problems their clients have community mental health teams, so they have ongoing care needs.

At this time when we're faced with a pandemic, there is a tendency to want to withdraw some of those services.

So not visit people in their homes, not have them come into community mental health clinics and so forth.

We're seeing this as an opportunity to really surge ahead with the rollout of digital platforms to support those people with complex needs in the community and not replace what is been the sort of raft of interventions and therapies that are being provided, but really provide another means another channel of providing services.

NORMAN SWAN:

So that sounds great, but complex needs are usually not around anything to do with mental health more to do with housing, transport jobs. How on earth does digital health help that?

JOHN MENDOZA:

In the same way that digital platforms help all of us tackle complex needs, I'm meaning they have complexities that are associated with their mental health condition.

So their inability to gain employment and, you know, undertake learning programmes. These things are all facilitated through digital platforms. So you're not just dealing with the mental

health domain, you're dealing with the other social and functional domains and providing people with greater access to those, those sorts of services.

Our plan is to provide a significant number of iPads with the data access requirements that people need. So where people don't have those tools, we want to provide them and based on some experience we had here a number of years ago with jobless families, we found the uptake of these the utility and the benefit for people was quite outstanding.

So we're confident that with a far more sophisticated digital mental health platform that we will be able to support these people with complex needs with severe mental health conditions.

Use these tools in a way to supplement what community mental health teams are doing now. And to some degree at risk of losing some of that face to face contact that they've got at the moment.

NORMAN SWAN:

So very new and shiny, how are you going to measure outcomes?

JOHN MENDOZA:

Well, we will work with our partners in this in is a partner in it. In terms of how we measure this, the platform itself does an enormous amount of data collection in terms of the user experience.

And, again, as everyone's mentioned here tonight, the importance of having consumer input into the way the platform is calibrated, if you like, to the needs of this particular group, so we're focusing on folk in the western areas of Adelaide.

So I'm talking about the Woodville out to Port Adelaide area. These are people with lower levels of digital access than say over in the eastern suburbs. And we'll be able to track, you know how they're going.

But also, you know, not, as I say, displace the relationship that they have with their key support worker, but supplement it and provide another avenue during this period where we've got constraints on those face to face interactions.

NORMAN SWAN:

Thanks, John.

Angelo Virgona, is Governor's Chair of New South Wales branch, College of Psychiatrists, and have various senior clinical director positions in the public system as well as being private psychiatry itself.

Angelo you know, psychiatrists, you know, the stereotype is they want to control everything. Not necessarily at the forefront have new ideas and integration with the rest of the system. Are psychiatrists going to be agents for change here?

ANGELO VIRGONA:

Well, I think Norman, the last couple of weeks has seen the most dramatic change in the behaviour of psychiatrists that I've witnessed in 35 years of being in the profession. So people have adopted telehealth platforms extraordinarily quickly, some of it driven by the need to maintain income, some of it driven by need to be able to ensure the health of the of the patients that they're looking after.

But essentially, we've just seen transformation. And I think we've also seen them use apps because we've got them online over the course of the last fortnight as well. So they've got platforms where they/forums where they can share information.

And I think a lot of them like me, have learnt an awful lot about how to use apps and how to share information online and access information online. And I think this sort of experience that they're gaining is going to inform the sorts of take up of new technologies, that sort of Ian and John .

NORMAN SWAN:

It's not just the new tech of new technologies, it's changing the model of care. We're talking about quite profound changes to how you look after your clients to patients.

ANGELO VIRGONA:
I think people are getting much more comfortable with the idea of being able to talk to and see people remotely. I had never used it as part of my practice I never had to, now it is all of my practice virtually.

And I'm finding that I'm able to, to provide a service which is comparable to the quality of service that I did previously. So I think everybody's having the same sort of experience. We also have the experience of…

NORMAN SWAN:

You are saying comparable but surely you would want to improve, surely the promise here is that you get integration, you get feedback you were able to monitor and so on, and it changes the way you deal with it. It's not just the one hour session that you might have as a billable thing on maybe Medicare. It's an ongoing relationship with the client.

ANGELO VIRGONA:
I agree that we haven't had we haven't been big on looking at outcomes. So now way of monitoring has been very much a personal clinical experience way of determining the improvement in patient care.

And I think these will these applications potentially can add a much better level of science to what we're doing..

NORMAN SWAN:

Thanks Angelo for that. Michael Moore's chief executive officer of the Central and Eastern Sydney Primary Health Network, active GP and had long interest in digital solutions, particularly with youth Mental Health Services. Michael, what are the risks? If you like really just telehealth? Are they real or imagined? Or what?

MICHAEL MOORE:

I think there are real risks. And I think, as Angelo has just said, you know, we are going through a very rapid transition.

We're in a fast car that sort of roaring down the road we got to watch out for the risks that are that are ahead of us. And you know, this is not a stage product, this is a very sudden, very rapid implementation.

And so, you know, there's a few things we need to look out for, I guess the scheme that I have in my head is, you know, what's, what are the organisation risks? And I'm talking about individual practices risks, what are the technology risks?

What are the risks to the person that's actually delivering the services, the psychiatrist that you know, has suddenly been thrown something that they've never dreamed that they would have to do and what are the risks that a client and there's real risk to the organisation because as PHN we deal with a lot of NGO mental health providers, and there's viability issues for someone, if they're not able to jump onto this cart that's rolling down the hill, this digital health thing very quickly within the next, you know, couple of months, under the COVID public health orders, they're going to become non viable services that are able to provide a service. And so that's a that's a big risk.

NORMAN SWAN:

You're going talk about those risks can put you off completely, are there ways of mitigating?

MICHAEL MOORE:

Well, I think, as a Primary Health Network, we're doing what we can do with the organisations that we contract with.

And so the kind of services that we would ordinarily provide to GP's and private allied health practitioners, we're now starting to provide those to NGO's as well.

And it's a tough call because you know, then they're bigger than the clients will normally have to deal with.

And so, you know, with the GP's, you can kind of go We'll here's the phone and then when you're comfortable with that, you know, maybe use Skype and then we when you are comfortable with that then you use an enterprise Level type tele consultation thing here like, you know, health direct or Innowell, Ian's very good product. And so, you know, there's a whole conversation we had with dealing with the NGO's, it's a big conversation.

NORMAN SWAN:

So this is not something necessarily one jumps in with your feet straight on you have to think about it a bit.

MICHAEL MOORE:

Well, unfortunately, we've already jumped in and we kind of have to think, while we're falling into the water.

Yeah. unfortunate. We don't have the luxury at the moment because of the public authorities of doing things any other way. So I think we're all doing a crash course in risk management.

NORMAN SWAN:

And presumably that emphasises getting the platform right in the beginning.

MICHAEL MORE:

Yeah.

NORMAN SWAN:

Sebastian Rosenberg is fellow at the Centre for mental health research in ANU and also the brain and mind centre.

And especially you've all you've had a long interest in in equities in mental health. It could make it worse because there are huge inequities in access to information and communications technology.

SEBASTIAN ROSENBERG:
Yeh that's exactly right Norman. So there are two main issues, I think with a better access programme.

There's inequitable access across Australia, which really based on the health professionals operate, and there's almost a complete lack of accountability.

So we're spending $30 million dollars every week now. And we know almost nothing about the health impacts of the spending should also say that's not really helpful.

NORMAN SWAN:

That's not tele mental health is it?

SEBASTIAN ROSENBERG:

No, I'll get to that. So this is showing, however, how good or well intentioned programmes can really run a riot quite quickly.

New clients into better access are only about one third of all clients every year. So the model of care and recovery is not at all.

So I was really pleased to hear from Peggy Brown that standards to be honest on we've had national mental health service standards since 1996. And it's very difficult to see them driving systemic quality improvement.

SEBASTIAN ROSENBERG:

There is already telehealth in mental health Norman.

In the outpatient setting, more than half of all community mental health services provided where the patient wasn't present lasted between five and 15 minutes.

Most of these were surely phone calls, made from hospital outpatients to the consumer to see how they're going. Now, in 2017-18, there were 2.2 million such services.

So I guess my question is, you know, is this good care? So my question really is, Will telehealth really drive better access to quality care, that is truly accountable?

NORMAN SWAN:

What's the driver for change?

SEBASTIAN ROSENBERG:
So look, you know, there are models elsewhere, where we have. First of all, there needs to be a proper thinking and investment, not just in the delivery of a service and the model of service, but in the model of accountability.

And there are templates elsewhere. You look at the way the AIBT was implemented in the United Kingdom with regular monitoring and reporting of outcomes. You look at the way New

Zealand implemented real time feedback from mental health consumers about their progress.

These are the way we need to be thinking about investing not just in services but in real, genuine accountability.

NORMAN SWAN:

Okay, we'll come back to some of the details on that. John Feneley is the Director of the Black Dog Institute, with a long career in public service, and a mental health commissioner in New South Wales.

You know John, to some of the family members who have severe recurrent mental illness, how could these systems be better utilised? And how do you answer some of the criticisms or cautionary tales of both Michael Moore and Sebastian?

JOHN FENELEY:

Well, I mean, I have to say, Norman, having spent a lot of time both from a policy-end but also with family members, I really hope that COVID-19 will be the disrupter that this very static mental health system needs.

I mean, the fact is, for a person who has frequent and persistent mental illness, oftentimes, every episode might as well be the first. I mean, the system doesn't learn.

As it goes, it's not very respectful of the person, and it certainly doesn't engage them in a partnership often.

And I think that necessarily, because the traditional models of care just aren't possible with the COVID-19 pandemic, we're having to look at new things. I should say that there are real concerns from my parliament that the mental health review tribunal, we've stopped doing any live hearings.

So we don't go into prisons, we don't go into hospitals, and I hope that doesn't go on for too long because I think there are areas where you do need a presence, you need to be asking difficult questions, which often get lost through telehealth style technology through videos. But this this opportunity where you start engaging people in a way that has the promise of giving them as much as they need it, the minute they need it and the time they need it.

JOHN FENELEY:

I think it's really promising seeing and hearing John Torous and also hearing Sam describe his involvement, I feel there's a lot of promise here because oftentimes the person isn't given

the opportunity to truly partner, for instance, isn't actually adding their own data into the system about what their experience is on a week to week basis.

So, you know, we see them in hospital, we surround them with care, we send them out into the community, and they may not see anyone very often at all, and they certainly don't have any input.

We still rely on the old 'you'll come and see me at this time', or 'I'll come and see you,' whereas what we've seen today through this webinar, is the potential for tracking all sorts of things on a much more regular basis.

But the person with lived experience having a role in that and having a conversation about that, which is much more real than it often is today. And I, without wanting to expose my own family members on privacy, the fact is, they've had many, many experiences over many, many years, and the system itself hasn't learned much about them in that time.

And I would hope that with digital technology where you can really give that person that is the person who lived experience a stake in that and a different type of relationship because the fact is, this COVID-19 will disrupt the power relationships that currently exist.

The fact that you might have a telehealth engagement with your psychiatrist or psychologist That, to me is a really positive thing, not the fact that should happen all the way like that.

But the very fact that a person has to traipse into someone's office to see them often at a level of knee when frankly, they would do just as well by via telehealth, I've got to tell you, it's been an eye opener for me in terms of my family member, we tend to ring them up now and realise that we should have been doing FaceTime and, and all the other things.

So I think there's a great promise in this as a disrupter.

NORMAN SWAN:

Thanks very much, John. Julius Ajayi is a Translational Mental Health Nurse Practitioner at the Kildare Road Medical Centre in Blacktown Sydney.

From your perspective as a nurse practitioner, Julius, what's the use you're finding for digital platforms in patients with mental healthcare, needing mental healthcare.

JULIUS AJAYI:

Thanks very much, Norman. Um, yeah, I've been a user of a digital Platform myself, it's given the opportunity to have patients come through because, you know, I'm based at a primary care sector, at a GP practice and you know, most people, they do trust their GP.

So they come in to, to onboard on the programme, and we've used it, we've been able to use the platform to, you know, do a bit of a screening for people who ordinarily would not have met the threshold for the tertiary or secondary mental health care.

So for example, people who maybe they got like, low to moderate you know, symptomology or people with psychological distress that, you know, they might be that they might benefit from psychological therapy.

The use of these, you know, a platform is actually opened that door for people to come in through the primary health care sector to their GP to access the service and get on the system and get it up platform to do their own, you know, sort of collaboration to their own self assessment, to come up with, you know, ideas as to how they want to move their health and mental health wellbeing forward.

NORMAN SWAN:

So it improves connectivity and engagement?

JULIUS AJAYI:

Absolutely. And also people who will not ordinarily you know, present to, for example, the community mental health team or walk into a mental health service will normally come to the primary healthcare to talk to the GP and by so doing, they can actually access you know, the digital platform to in their own, you know, home environment, be able to do their own self-assessment and can use that as a way to engage their clinician and ask for their needs.

For example, somebody who is having some sort of high anxiety level or maybe some psychological distress will be able to use that platform to say to their GP, I think I need psychological self-therapy to deal with my anxiety levels and straight away without wasting time, the GP mental health care plan can be put in place.

NORMAN SWAN:

So it's highlight those efficiency gains as well. Julius, thanks very much indeed. Associate Professor Liz Scott is a Consultant Psychiatrist at Mind Plasticity; Discipline Leader of the Young Adult Mental Health Service at St Vincent's Hospital School of Medicine Sydney; and the Director of the Young Adult Mental Health Unit at St Vincent's Private Hospital Sydney. Liz, are you currently flipping your clinic with technology?

LIZ SCOTT:

Norman we are indeed we have, what's remarkable, I agree with Angelo is what would have taken two years of persuasion, negotiation and pushing we've managed to achieve in two weeks and it's been really interesting some of their kind of initial response to that, one of the

most important things is that young people and their families have really rapidly adapted to this change.

So we flipped our multidisciplinary community clinic, we've also flipped our specialised hospital outpatient clinic, and we're in the process of trying to flip our inpatient service to a telehealth but also our digital health kind of service.

NORMAN SWAN:

Inpatient? Just explain that one.

LIZ SCOTT:

Yeah. So at the moment in the COVID era, obviously admitting young people to an inpatient unit, especially as we're at Vincent's Hospital, we're in the kind of epicentre of the current COVID cases is challenging.

So it's given us the opportunity to look at how we might run a kind of stepped care less, you know, look at less intense levels of care and look at hospital at home treatment.

So how would we provide a platform that would allow us to treat people in their own homes, with the collaboration of community clinicians and families so, so really to look at, you know, what would have taken us a long time to put in place we now think that we could actually do quite quickly with a digital platform that would allow us to track and monitor, and importantly, to escalate care.

So, really to provide care according to the person's needs and the intensity and severity of their symptoms, rather than to when their next appointment can be scheduled.

NORMAN SWAN:

In any sense of the quality of care, I mean, this sounds like a compromise. You can see it as a compromise or you can see it as disruption for improvement.

LIZ SCOTT:

I think it's I mean, it's disruption and I think it's really something that needs to be tested. What are the elements of care that can be provided at home, what would be the advantages of that and keeping young people within their community, within their school, within their job, for instance.

So not causing the dislocation that hospital care can provide, but also about efficiency, we could treat more people, we could provide more specialist services, provide better access at lower costs, work with young people and their communities, provide better skills.

You know, upskill people around the community and keep hospitals' inpatient services for those people that really need the care for the treatments that can only be provided in a

hospital environment or for those people who really are not able to access those other forms of care or don't have the support available to them.

NORMAN SWAN:

Thanks Liz. I mean we could talk a lot about digital natives with younger people who are more used to these technologies and we have access to as well. But what about older groups of people?

And here we have Dr Haley LaMonica, a Senior Research Fellow and board-certified clinical neuropsychologist working at Central Clinical School, University of Sydney. What about use of technology, Haley, for older people in Australia?

HALEY LAMONICA:

Well, I think Norman the idea that older adults can't or won't use technology is really a myth that we just need to throw out the window.

Back in 2014, 68% of older adults, so people over the age of 65 in Australia, were using the internet, and this is actually the fastest growing group of internet users.

And also, in fact, they're the fastest growing group of gamers, which is quite fascinating as well. And through our group at the Healthy Brain Ageing program, we ran a survey and actually 95% of our respondents, so this is a group of older adults over the age of 50 indicated that they were interested in a platform or website or something to support healthy ageing, their own health and wellbeing.

So there really is a desire for this type of digital support. And I think really, for those who aren't currently engaging with technology, it's not generally an unwillingness or lack of interest, but really a need for some guidance or some training around the how’s and the why’s of it.

So I really liked, I think the phrase was digital navigator that John Torous brought up earlier, I really like the idea of incorporating that into services now, to ensure that we're able to sort of upskill people in terms of the use of this technology for those who may not be essentially literate.

So I really think COVID gives us an opportunity to bring those older adults who aren't currently online, get them online, and really upskill the group in terms of how to use these technologies, one for social connection really, because this is going to be the group that's potentially most isolated and for the longest period of time, but also to ensure really, that they're able to access the care that they that they need.

Norman Swan: Thanks very much Haley. Jason Trethowan is the Chief Executive Officer at headspace National. Jason, let's talk about waiting lists and digital health. I mean, headspace tries not to have waiting lists, but you inevitably do.

JASON THRETHOWAN:

Yeah, thanks, Norman. Look, I think, talking to Ian Hickie about this today and that, not surprisingly, when you promote mental health and wellbeing and opportunities to access services, you shouldn't step away from that just because there's wait lists or, or capacity issues, but we do have to think differently.

And I think the COVID crisis is doing a couple of things. One is that it's going to, for young people, it's going to unearth a whole another waiting room for young people who are perhaps stable in their life, they're going through university, things are going pretty well, stable employment.

And all of a sudden for the first time in their life for many of them, this is a massive disruption. And this is going to really challenge their own mental health and wellbeing; their goal setting may be different, the things that they enjoy the most and doing them often have been taken away in this hopefully what is going to hopefully be an interim period.

So what do we have to do? I don't think it's just about having more clinicians on the ground and clearly now with the digital opportunities or the innovation that COVID now provides, is that we have to look at not just replacing the face to face with telehealth. For young people, what is telehealth?

Oh, is that what you mean, it's just online? Okay, what else? And the what else has to be credible resources that they can engage in not just static information like a fact sheet on what is depression or what is anxiety?

If I'm homeless, and I've got anxiety, and I've been bullied, I should be able to see myself through three merged dynamic pieces of information that starts to talk to me as opposed to me reading three isolated pieces of information.

It should allow me to engage at any time with peers who are going through very similar lived experience, I should be able to webchat, I should be able to SMS. Video?

Yeah, okay, I'm happy to do that, if that's the way the funding system says I can do it. I'm happy with a phone call as well.

So the waiting list issue and young people in the demand we shouldn't, you know, obviously, when we're used to the term waiting lists when it comes to acute outpatient services and others in hospital settings, but the mental health system…

NORMAN SWAN:

Sorry, we're just running out of time, but I understand the point you're making about flexibility.

Ian made the point right at the beginning I think John Torous made it as well is that video is an essential element here.

This is about human face to face interaction. Very hard to actually do this by a simple telephone call. So all of this endless flexibility may not be getting you to a better place.

JASON TRETHOWAN:

Yes, that's right. What I'm saying is that it is a menu. It's a shopping list of opportunities for young people to engage.

And of course, we've experienced so far, Norman, that young people in some cases are opting out. And they're going wait until face to face returns as they don't have the data, they don't have the internet access, that perhaps we would love them to have.

We're not a homogenous group, and so we have to have the menu and the shopping list, to be able to be there for young people on their terms, and obviously, all credit to the clinicians who have just made such a rapid transformation across the country, in all disciplines across mental health and other physical health, who are now working in a very different way.

We're going to learn an incredible amount about what it's like over the next six months and I think now that the genie is out of the bottle, it's going to be hard to put back in.

NORMAN SWAN:

Frances, let's go back to you for a moment. Frances Kay-Lambkin, have you got any examples of peer support? I know I was talking to Sam about a moment ago.

FRANCES KAY-LAMBKIN:

I do, and I'm very happy for them to weigh in here. We have a platform called the Eclipse platform that does this kind of navigation function.

And Ian's talked about his platform, and there are other ways in which people can help decide for themselves what it is, is the best and the most credible for them to engage in.

And one of the things we've been working with is this social networking platform. And I will just make the point that this is building on and leveraging the way we tend to connect in today's world.

So we're all using the same tools and concepts that people are already using to connect with each other. A lot of people don't want to talk on the phone or don't want to necessarily use video and young people particularly are happy to text or communicate in images, things so we're already doing this in other ways, and it's just bringing that way in which we're connecting today to this issue of how we connect about our mental health and wellbeing.

And one of the wonderful things I think, is that it's also providing a platform for our peer workforce in mental health, who are a very important part of our workforce and our response to mental health issues and mental health support, to be able to connect with each other and to be able to provide that support across a wider group of people than currently.

And so through the tools that we've been using, it's been really humbling to see that most of the benefits and those life changing moments that occur actually between peers. So people who have that shared with lived experience of helping each other and supporting each other and I think this group are our digital navigators.

Often they've been through the systems, they know what works and what doesn't work, and they are often in this great position to be able to provide that kind of support, particularly in this time because they're doing it already.

NORMAN SWAN:

Thanks very much, Frances. Danny Rock is the Principal Advisor, and Research Director of the Western Australian Primary Health Alliance.

Can you just talk about digital mental health and how it will interact with established mental health services, particularly those who rapidly transferred their face to face provision into digital offering?

DANNY ROCK:

Yeah, thanks Norman. We went through our COVID moment three years ago, I think when we got the guidance from the Commonwealth when it closed down ATAPS to do something different and better.

And so we've tipped up a digital psychotherapy service, and I think I think the design phase was about a week and then about three months to stand it up in place, and the services, called ports, we were relatively conservative about what we did, and it's online but an app based programme.

I thought I'll go through that, and then I'll maybe talk about some of the lessons and challenges quickly and then the brave new world.

So the poor service is our mainstay provision it as I said it operates on the mind spot platform and between Nick Titov's group. And the advantage for us for that was that they have the technology the expertise and the knowledge to do to do this.

It's a preservice GP referred fundamentally as measurement based care. So there's a feedback loop to the general practice and the person receiving care can see their progress themselves.

And it's a combination of when we say digital, it's phone based, internet based, but we still use paper workbooks for some regions so that so it's what works. Adults up to up to the age range there 96 years. I think we've done 4000 patients so far.

NORMAN SWAN:

And what are the results you are getting so far, Danny? Sorry, we are running out of time.

DANNY ROCK:

People get better, but it's not miraculous. People who are severely unwell become get to a certain moderate level of wellness.

People who are moderately well get to a cope-able mild level, and so forth. What's really important, Norman, is we follow people up at three months.

Because it's all well and good to be doing something in this digital space, or any space. But we have, and we sustained it three months. And what's most striking for us, it's not just simply distress going down.

But as a fundamental measure, people want to get their lives back. And this this gives them their lives back. And it's not so intrusive in their lives that they're overwhelmed because many people we're providing care to, they've got, they're already overburdened. They're coming into care with, you know, six days on a roll.

Treatment is not exactly free in terms of burden, and we're adding into their burden. And we have to be mindful of that. The other thing that's really exceptionally important in this is I'm looking at the panel here, we're the weirdest people in the world.

I mean, we designed, conceived in developing these things, and then we optimise them in our cities, but we don't really actually understand that optimisation has to occur in the real world. When I was Director of Research, everything we did worked, it was fabulous.

It was in the western suburbs of Perth. It was just when we did it in the real world, things started to go a part a bit.

And I think that's why we need the support and mediating structures for digital health that Peggy was talking about, because in the absence of those, this grand transformation will fail. So for organisations like us, we're lifting up and it's our core business.

But if you're existing in the kind of organic cottage industry of psychotherapy that there is the better access system, you're going to go from a pre-industrial to a post-industrial provision in one step in the face of a real threat, an existential threat.

And we'd like to get you there in 30 days. And it seems to me at least that we seem to be applying for different tenants.

Say for example, the vaccination we're trying to develop and saying this is going to take a year, and we have to hold on and apply a completely different standard to the provision of psychotherapy suddenly, as if you can substitute it as if it's a digital thermometer. So we're taking the mercury thermometer, when in fact, the process is a whole scale workflow redesign. And that's fundamental. I mean, it's just a habituation approach is not going to work.

NORMAN SWAN:

Thanks, Danny. Ian, we're running out of time. Can you just summarise some of the questions that have come in and what the possible answers might be?

IAN HICKIE:

Yeah, look, thanks to everyone for their very detailed replies here. I've been typing furiously, big issues around professional training. Do we have professions to actually do this? No, the professions will have to train to do this differently.

IAN HICKIE:

Will we actually focus on increased quality of care and not be a degraded experience? That we need to have to track.

IAN HICKIE:

Are there any unintended consequences in certain situations? You know, you have to assume when you mess with a health system in the real world, as Danny was just alluding

to, stuff's going to happen that you didn't predict from earlier smaller focus trials, so we need to monitor that.

The quality and safety environments and so the issues that Peggy was emphasising I think, are absolutely critical, and that they are understood both by user services and providers and services, and particularly the ones judgement models of care.

What are we trying to achieve here? Better care at scale, more personalised, more transparent. Not a degraded experience, from traditional face to face care. And I think what most people have been talking about is digitally enhanced services, not digital health versus clinical health.

But how do the two come together to actually give a better experience and the individual mix will need to be negotiated by the individual at the service level, but also by the different services, the whole integration of mental health.

And the change and the disruption that's happening – I love Angelo's comments, everyone, even the older psychiatrists, like me and him – suddenly have to be really different as the world just changed. And the tools are sitting there for us to engage in. We're all part of health systems, and as the providers for the better care for those users, we need to work right across the spectrum of mental health.

IAN HICKIE:

Lots of people raised, *will we provide a lot of the resources?* I've answered as many questions as I possibly can during this time, the output from that and that will drive us into other issues.

So somebody's been asking for us to recommend specific platform specific apps particular tools. We've avoided that during this particular overview, but we will come back to that in very specific areas of interest.

You mentioned some Norman, of comorbid, substance abuse, critical errors, others in aged care, common anxiety and depression, common sets of issues. So we will, in future seminars pick up those very specific issues, and less of the overview that we've had this evening.

But if I could thank everyone, including you, Norman, for facilitating what has been a long and complex list of questions. It has been our goal to give people an overview. There's a tremendous amount of wealth here.

I think Danny's point is critical. A lot of has been done in narrow, focused areas by enthusiasts in the area. We're now talking about big health system reform, not tele, but digital enhanced care, not a degraded substitute for current clinical care. And that requires us all to behave very differently in the future.

NORMAN SWAN:

And thank you to all our panellists, you all contributed immensely to this. This is the end of the beginning, if you like the conversation here with *digital* mental health, there will be more as Ian has promised, and I thank you all very much, who participated and listened to this conversation.

And hopefully you'll engage as we move forward and as Ian said, he'll try and reply as much as possible to get as big a community as possible to have an ongoing conversation.

IAN HICKIE:

Finally, Norman, this is available through Sydney Ideas. So it comes off the Sydney University website, Sydney Ideas and that will be the critical link to follow up just flashing up as we look at that as I speak! Magic.

So these are the useful resources, including references, future webinars, and particularly the Q&A which has been running furiously in the background, as well as other issues. We will then send out through the Sydney University Sydney Ideas website.

Thank you all very much. That's good. Nobody's going to go anywhere tonight, but if you are, go safely.