Medical Board of Australia
Guidelines for telehealth consultations with patients
Open for consultation until 17 Feb 2023

Herewith my submission:

Transforming Australia's Mental Health Service Systems (TAMHSS)
PO Box 110 Balmain NSW 2041 ███████████████   ██████████████

I am Professor Alan Rosen, AO, Chair of TAMHSS
(Affiliations below)

My concerns are as follows:

1 There is no consideration of seeking the optimal balance between digital telehealth and person to person assessments and reviews, including the need for home outreach and home visits   This is an important clinical & ethical consideration, especially for individuals with severe and complex psychiatric and cognitive disorders and their families, rural and remote individuals, transcultural and indigenous clientele, and those with disabilities affecting their communication abilities   See attached article for American Psychiatry Association Psychiatry News, 2021, and Report to Senate Select Committee April 2021

2 Consideration of the needs and criteria to include or exclude family members and other caregiver viewpoints, and the need to systemically address the lack of regular liaison by telehealth practitioners with the person s GP and family, and with regional mental health service care coordinartors (see appendix 1 below)

3 The continuing inadequacies of the Digital/Telehealth Standards of the Safety & Quality Commission (see appendix 2 below)

Appendix 1:

Extract from our TAMHSS submission to the Productivity Commission Draft Final Report on Australian Mental Health Services: Telepsychiatry and other Telehealth mental health services

Psychiatrists and other clinicians offering telehealth consultations and advice are best provided in combination and balance with intermittent in-person psychiatric consultations and reviews, optimally by the same psychiatrist or by the same rostered and collegiate group of psychiatrists, providing local team and GP consultation, and clinically hand over to each other. Such a combination should provide better engagement, greater accuracy of assessment and review, better appraisal of physical health needs, better communication and clinical supervision with local GPs and community mental health teams, and better peer review. While telepsychiatry and telehealth counselling are now becoming highly valued components of mental health services for rural and remote communities, it should be part of a mixed and balanced economy or well integrated spectrum of mental health services. It should not be offered as a stand-alone service, particularly in rural settings, without firm Commonwealth, Medicare and RANZCP requirements to act in close and regular clinical communication with GPs, community mental health teams, and families, especially if agreed by the initial service-user. It is often community mental health teams who have to deal with ensuing crises and acute admissions, sometimes by complete surprise, as telehealth practitioners are not required to do nor are they separately reimbursed for such regular communications.

Recommendation: Telepsychiatry:

Medicare subsidized doctor and psychology/allied health telepsychiatry and Telehealth Mental Health Services, where needed for the regional mix of clinical services, should be strictly contracted and regulated by Regional Commissioning Authorities. Under these provisions they should be obliged to:

1 **a) eliminate or severely limit gap co-payments, particularly for priority service groups including remote, transcultural, indigenous, etc**

2 **b) liaise regularly with GP's and in rural & regional settings with community MH teams if there is a risk of presentation to public services, and with families (with permission of the service-user if voluntary),**

3 **c) be governed by a single regional MHS plan integrating all public, NGO and any privately contracted MHS. This plan should have some formal obligation status such as strictly operated contracting, rather than just a loose in principle service agreement.**

Appendix 2:

Re: Telehealth Safety & Quality Stds :National Safety and Quality Digital Mental Health Standards

We welcome these 3 standards for mental health telehealth covered in discussion paper and your presentation

I have been employing both telehealth and in-person care for many years with remote & Aboriginal communi4es, and as co-authors of the National Mental Health Service Standards we (Viv Miller and)I both sustain our strong interests in all mental health service standards

I do understand the limits of specificity that the Commonwealth can impose or even recommend, but more explicit guidance is needed (among other concerns) on:

1 getting an optimal balance between telehealth and face-to-face care, including assertive outreach and home visi4ng , whether during the COVID19 era or well beyond, with adequate & systematic safety procedures and equipment as required

2 Ensuring that telehealth practitioners communicate both routinely & regularly, AND also urgently when needed, with designated care coordinators, families and the referring general practices, for which there are little or no financial incentives as yet to shape fee-for-service practice

Sections (as listed below) of the **Model of Care** standard come closest in touching on these concerns but are not yet sufficiently explicit in its expectations or guidance

1 **Delivering the model of care**
The care delivered is consistent with the model of care and provided in partnership with service users

2 **Communicating for safety**

Service providers have systems in place for effective and coordinated communication that supports the delivery of safe and high-quality care for service users

3 **Recognising and responding to acute deterioration**
Service providers have systems in place to recognise and respond to acute deterioration in mental state

With best wishes
Alan

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We Need to Find Right Balance Between Telehealth, In-Person Care

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Many community-based mental health practitioners have welcomed the focus on telehealth in response to the COVID-19 pandemic by governments around the world, yet there has been little or no focus on enhancing face-to-face and home-visiting services when needed, with appropriate safety precautions.

In a recent article in *Psychiatric News*, James Shore, M.D., and Peter Yellowlees, M.D., correctly noted that the much wider psychiatric use of telehealth in response to the COVID-19 pandemic has been transformative (*[Psychiatric News](#)*). We need to ensure, however, that this transformation doesn't also overextend to replacing in-person care almost completely with telepsychiatry for mental health assessments; reviews; and crisis and disaster interventions, especially in community, regional, rural, remote, indigenous, and forensic settings, as detailed in an international review published in the July 20, 2020, *Current Opinion in Psychiatry* by me and my colleagues, Luis Salvador-Carulla and Gill Neeraj.

The needs of people with moderate to severe mental illness were often poorly served prior to the pandemic. This represents a pre-existing crisis as the mental health systems in many countries were already broken, depleted, or under extreme strain. In addition, many people living with mental illness and psychosocial disabilities were already existing on the margins of society, and so they have been extremely vulnerable to the pandemic and its associated economic recessions and high levels of unemployment. Many are isolated, homeless, and at risk for suicide, and others may

be living at close quarters with families who are critically in need of support themselves.

In the shock of the initial phases of the pandemic, public, private, and many non-governmental organizations (NGOs) that provide mental health services saw a sharp drop in face-to-face care and a withdrawal from home-based and assertive outreach modes of providing such care, just when it was greatly needed for a wider range of people who were more isolated than ever. In part, this was related to justifiable concerns about patient and staff safety, often including deficiencies of personal protective equipment, explicit procedures and training for safe home visiting, and community transport of patients and their caretakers.

While many clinicians have put their own health at risk to care for their patients, others have shown poor leadership. Some senior clinicians, even those not in designated vulnerable health or age categories, have withdrawn to work only digitally from their homes and offices. Severe losses of in-person crisis backup by mental health clinicians has been experienced by NGO community support workers. In addition, telehealth is still too expensive and inaccessible for many vulnerable or marginalized people, and many still lack the connection costs, skills, hardware, or privacy to use digital devices to benefit from telehealth services.

We can no longer put off prioritizing care for people with moderate to severe, persistent, and complex mental illnesses and suicidality, whose numbers will only continue to swell as further climate-related domino adversities unfold. We need to find an optimal balance between digital and face-to-face and outreach services for these patients. A call to action to this effect was directed to the Australian federal government in mid-2020, co-signed by many leading psychiatrists, other clinicians, and academics, including practitioners who provide both in-person and telehealth services.

There are increasing numbers of published studies on telehealth systems used in recent disasters, but they are predominantly descriptive. They tacitly or explicitly encourage public mental health teams to "pivot" (in contemporary management jargon) almost completely to telehealth provided by hospitals and clinics, without providing rigorously controlled evidence of telehealth's comparative or equivalent effectiveness. Telehealth suits some clientele but not others, and some expert U.S. "hybrid" (combined telehealth and in-person care) clinicians suspect that such "pivoting" solely to telehealth consultations can often be much more safe, convenient, and lucrative for practitioners than it is effective for many of the individuals and families who need to be served.

One key solution is to deploy more evidence-based assertive mobile community-based mental health teams integrated with and augmented by telepsychiatry services. However, we need an optimal and adjustable "hybrid" mix of both face-to-face and digital services and to encourage the use of digitally enhanced in-person and home outreach services in all regions.

The legacy of lessons from previous disasters and the likely exponentially increasing demand for mental health services due to climate change crises suggest that we need to develop and stabilize this balance for the future, making these arrangements more equitable and ongoing. Government responses to addressing the continuing mental health impacts of trauma and prolonged economic consequences of environmental disasters need to be sustained on an ongoing basis, not for just a few months at a time. These problems may ultimately affect not only those with the greatest disabilities and socioeconomic disadvantages, but ultimately all of us.

Ample subsidies for adequate digital equipment, network access, and training to use digitally enhanced services must be made available to patients and their families who need them. Service managements must ensure the availability of personal protective and other safety equipment and procedures and pastoral support for patients, health care personnel, and support workers.

Both during and beyond this pandemic, we must call on all governments and mental health service systems to ensure that an optimal range and balance of telehealth, person-to-person, and mobile outreach community services, including inpatient care and residential alternatives to hospitals, are accessible to all populations in need. ∎

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2. Knoedler D W, Telepsychiatry Is a Team Sport. June 25, 2014, *Psychiatric Times*. Volume 31, Issue 6.
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5. Rosen A, 19 April 2021, Dominos: Mental Health Impacts of Australia's Environmental Crises. Invited article, Earth and Psychiatry series, *Psychiatric Times*, USA.
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7. Torous J, Jän Myrick K, Rauseo-Ricupero N, Firth J Digital Mental Health and COVID-19: Using Technology Today to Accelerate the Curve on Access and Quality Tomorrow. *JMIR Ment Health*. 2020;7(3):e18848 doi:10.2196/18848 PMID:32213476 PMCID:7101061.
8. Yellowlees P, Shafqat S, Myers K. Indirect consultation and hybrid care. In: Yellowlees P, Shore JH, editors. Telepsychiatry and health technologies: a guide for mental health professionals. American Psychiatric Publication. Arlington, VA. 2018. p. 251 – 288.

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Vn C: Update.18.04.21

Telehealth Services for Fireground regions & COVID related mental health services:

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Summary:

- We welcomed the first waves of mental health responses to the COVID-19 crisis from the Commonwealth Government, and Health Minister Hon Greg Hunt. Many largely focused upon the whole population through on-line or e-health information, triage, crisis counselling services, and telehealth, but much less so, if at all, on enhancing face-to-face and home visiting services. This resulted on rapidly "pivoting" many primary and specialist mental health care services from face-to-face to telehealth.
- Although telehealth enhancement was often the sole or predominant response, it was often withdrawn too early, or extensions of these arrangements were often brief and discontinuous, or still too expensive and inaccessible for too many.
- We also appreciated the unprecedented steps taken by Government to preserve livelihoods through the crisis via various economic stimulus packages. The safety nets that have been established are crucial to prevent loss of jobs and livelihood, which harshly impact on people with more severe forms of mental illness. However, such support has often been too restricted, with too many exclusions, or is being curtailed too rapidly.
- There is now an urgent need to move the focus to people with moderate to severe, persisting and complex mental illness, and suicidality, whose numbers are swelling as further adversities unfold.
- We may have an unbalanced over-reliance on and possibly only transient provision of telehealth for extreme bushfires and COVID19 by the Commonwealth Government mental health response plans, without adequate operational or ethical guidelines nor adequate investment for parallel provision of local in-person services required for an effective mental health response to these circumstances.
- There are now concerns, shared by at least some Senators on this Senate Committee, that the temporary implementation of these telehealth provisions could now be followed by downgrading, curtailing or withdrawal of Commonwealth mental health telehealth Medicare arrangements in vulnerable regions where the prolonged depletion of familiar local mental health services still has not been addressed.

Update re events since this submission was appended to Hansard on 31 August 2020.

Balance between Telehealth & Face to Face &/or Outreach services IS a leadership issue--it requires role modelling from the top.

This has been particularly topical recently because Commonwealth Government COVID & bushfires mental health responses mainly funded only distant on-line e-Health advice services and telepsychiatry and mental health telehealth. They made this narrow response, despite expert advice

that regional mental health services, including most firegrounds, had local in-person services which were very depleted of familiar staff to provide intensity and continuity of care, and that these needed urgent intervention from the Commonwealth Government to work together with the states and territories to rectify this. This prompted our collective call-for-action in April 2020, by psychiatric and other clinical experts (including presidents of the Federal AMA, RANZCP & World Psychiatric Association, and two Australians of the Year, as co-signatories) re these urgent concerns to Government. This led to my testimony and report (below) on the mental health impacts of, and adequacy of responses to our recent national disasters to the recent Senate Committee Inquiry on Lessons from our extreme bushfires and pandemic, and other likely sequelae of climate change.

Then, although telehealth was the main clinical emergency response to both bushfires and COVID19 which the Commonwealth Government had funded, they only did so temporarily, and had not announced any arrangements to continue COVID19 Medicare telehealth items for all regions beyond 30th September 2020.   It left in limbo and in doubt the main and only substantial clinical strategy to these disasters to which the Commonwealth had made a commitment, that is telehealth. It therefore threatened to pull even the only remaining mental health rug or safety-net (distant telehealth with bulk-billing for the most vulnerable categories) from under the feet of those who were most likely to be victims of these disasters. Despite widespread advocacy by the health and mental health sectors for months to extend these arrangements, of which these efforts were part, notice that these arrangements were to be renewed was not provided until 18 September 2020, 12 days before they were to expire, though again only for 6 months, with (as from 20 April 2020) bulk-billing continuing only at the discretion of clinicians, rather than being guaranteed for high vulnerability or victim groups. Short notice for notifying any extensions of this scheme continue to cause instabilities and disruptions of engagement as telehealth practitioners wound up their digital practices in anticipation of the scheme ending, and with their accustomed clientele returning to their waiting rooms. Further, addressing the future of telehealth on 16 April 2021, Associate Professor John Allan, as President of the RANZCP stated: "I have recently written to the Australian Prime Minister and other Members of Cabinet to welcome the extension to COVID-19 telehealth item numbers until the end of June 2021. This however does not provide ongoing, safe access for patients, particularly those who may be vulnerable to COVID-19." He also "advocated to the Prime Minister for the extension of COVID-19 telehealth, alongside all existing MBS Telehealth items for psychiatry, until at least the end of the year." Even this would be piecemeal and inadequate, as the Federal government's main mental health Covid response in the face of persisting uncertainties, socio-economic pressures and stressors precipitating more episodes of mental illness and the unaddressed depletion of public mental health services.

There are increasing number of published studies on telehealth use for mental health in recent disasters, but they are mainly descriptive, and often simplistic, implicitly encouraging public mental health teams to "pivot" almost completely to more sedentary telehealth, without providing rigorous evidence of comparative effectiveness, nor adequate balance with face-to-face and outreach home visiting services, whenever possible and necessary, and with proper safety precautions. Some senior clinical leaders, even those not in designated vulnerable categories, role-modelled this by switching their attendance to "virtual" only. However, we need an optimal and adjustable mix of both, encouraging hybrid digitally enhanced face-to-face services (and vice versa) in all regions. The legacy of and lessons from these disasters and likely exponentially worsening climate change, for mental health services, are that we will need to stabilize and develop this balance further for the future, making these arrangements more equitable and ongoing. Government responses to ameliorating the continuing mental health impacts of trauma & prolonged economic consequences of these disasters, need to be sustained on an ongoing basis, not for just a few months at a time, nor without further Government commitment for the future. Having such arrangements left in limbo and uncertainty until funding and services are just about to fall off the next cliff, may have led to many practitioners turning away from serving disaster-affected

communities in anticipation, and further exacerbation of feelings of neglect, abandonment, isolation and traumatic anxiety in affected individuals and families.

The subsequent core Commonwealth Government budgetary measure to meet the escalating mental health surges prompted by recent disasters (6 October 2020) was the increasing of Medicare subsidised Better Access mental health consultation sessions, including Telehealth applications, from 10 to 20 per annum, at least while the pandemic persists. This may be seen as helpful to a minority of service-users, and may be well-meaning, but may not benefit the majority of persons in most need (Rosenberg S, Hickie I, 2019, 2020).   This is due to gap payments supplementing the subsidy being set at the sole discretion of practitioners (rising to whatever the market will bear) which can still be a prohibitive obstacle to affording and accessing these services; maldistribution of fee-for service practitioners, favouring wealthy urban areas; lack of mandatory evidence based content and quality monitoring; the new 20 session limit inevitably resulting in long wait lists, decreasing access by individuals with new episodes of mental disorder or suicidality. There are mounting indications that this scheme, in its present form is overly expensive, too open-ended, poorly targeted, unaccountable, ineffective in containing costs to service users, and having never been demonstrated as yet by rigorous research to be cost-effective.

Previously in the term of this government, the Commonwealth Ministry for Health had declined to directly fund public community clinical teams, except for headspace and related services. However, the Commonwealth Government have tacitly recognised the severe pre-existing depletion of community mental health services, and set a national precedent for direct federal funding of community mental health services, during the recent spike of COVID 19 infections in Victoria, by funding 15 new free community mental health centres with multi-disciplinary teams (9 urban, 6 regional) for 12 months in that jurisdiction (announcement by Hon G Hunt, Commonwealth Health Minister, 14 September 2020). This has set a welcome precedent, together with Minister Hunt's recognition of the need to fund interdisciplinary teamwork for eating disorders, and his announcement of a subsequent development of a new Adult Mental Health community hub pilot site in each jurisdiction. Hopefully these initiatives will lead to more consistent Commonwealth Government involvement in working nationally with all jurisdictions to ensure adequate access to and funding of interdisciplinary community mental health teams for all age groups and all complex disorders.

Introduction:

Many mental health practitioners and some service users have found telehealth consultations helpful during the COVID 19 Pandemic. The many advantages of turning to telehealth mental health practice during the pandemic and opportunities into the future have been lauded in some largely descriptive uncontrolled studies and enthusiastic commentaries with few caveats. There have been fewer but much more nuanced expert reflections upon the opportunities provided by advances in telehealth utilisation for person-centred care and accountability, especially in rural and remote locations, if telehealth/telepsychiatry is done properly, including communication with families, care coordinators, referring GP practices etc and in optimal balance with face-to-face care when needed (eg Rock D et al, 2020, Rock D. 2020, Rosen et al 2020a).

Together with colleagues Dr Dorothy Kral, and Professor Peter Yellowlees (subsequently, Professor of On-line Health, University of Queensland, & then at University of California, at Davis, Sacramento) I was among the very early adopters of telepsychiatry and mental health telehealth in remote Australia and with Aboriginal communities from the 1980's. I have always favoured the practical, ethical, integrated and expanded use of these tools to augment our clinical practices, and still do so.

Our most recent concerns have been for the potential for withdrawal of these concessional COVID 19 arrangements by 30 Sept 2020 for psychiatrists and other mental health professionals doing telehealth

consultations in parallel with the precedent set earlier this week by the Commonwealth Government in curtailing GP Medicare arrangements for Telehealth. Also, it is clear that a substantial proportion of fee-for-service psychiatrists doing telehealth now, intend or are likely to revert to their more habitual urban local practices in their rooms when the COVID19 separation requirements recede and their own usual clientele return.

There are parallel concerns with the possible transience of the recent belated replacement of local familiar public mental health professionals on the ground, whose positions have been depleted by the jurisdictions over some years, (including and especially in many of the extreme bushfire areas) by distant stranger mental health professionals working by telehealth. The current subsequent risk of having the latter telehealth services withdrawn by the possible curtailing Commonwealth Medicare arrangements, while the long-term impact of trauma will carry on for many years, may disrupt any prospect of any expert ongoing continuity of care (see my attached statement on deficient arrangements for the firegrounds, prepared for the Royal Australian & NZ College of Psychiatry, which informed my testimony to the Senate Committee on learnings from the bushfires: Rosen A, 2020b).

For example, what is the evidence for the anticipated impact of ending assured rather than discretionary bulk-billing arrangements for telepsychiatry/mental health professional telehealth sessions for those individuals and families affected by fires and the fire-fighters and their families?

1. Crucial Role of the Commonwealth Government

The Commonwealth Government should urgently take an active role in work with, provide financial signals to and incentivize the states & territories, to replenish the depleted familiar local teams, restructuring them in more evidence-based ways. This should be done especially in regions with most vulnerable populations affected by prolonged droughts and floods, extreme bushfires and COVID 19, by providing enabling financial incentives, offers that they can't refuse to meet half-way. This would offer immediate relief for the firegrounds and most vulnerable pandemic-affected regions, as well as providing timely pilots for coherent, cost-effective services for the future.

Professor Hickie stated recently (Hickie I, 2020) : "Unfortunately, some of those areas most affected by the fires have very low access to these services. Traditional Medicare-based mental health initiatives have never delivered in these regions and they won't get the job done now. Governments will need to look at other higher quality and more effective options. This is a time for the nation to act on evidence and not just rush to well-meaning but often misguided responses".

The Commonwealth Government needs to urgently take an active role in working with the states and territories, ensuring a balance between enhancing evidence-based in-person mobile outreach community mental health services and enhancing telehealth services to minimize unnecessary person-to-person contact on safety grounds. At the same time, they should ensure the safety of all clinical and support workers. [See the Expert Clinicians Call for Action attached].

To this end, the Australian Commission on Safety and Quality in Health Care (2020) has been developing National Safety and Quality Digital Mental Health (NSQDMH) Standards, via an extensive consultation and airing process. This is a potentially positive development. However, while of the 3 draft standards, sections and indicators of the "Model of Care" draft standard come closest in touching on the concerns in this paper, they are not yet sufficiently explicit in their expectations or guidance to effectively shape or monitor, for quality improvement purposes, the ethical behaviour and evidence based practice of practitioners or mental health service systems. Hopefully, these will emerge in their ultimate versions, or in the subsequent detailed processes (including guidelines and indicators?) for their implementation to be worked on jointly by ACSQHC and the Commonwealth Department of Health.

2. Achieving a balance between Telehealth & In-Person Mental Health consultations

RANZCP Telepsychiatry guidance needs to promote a balance with in-person engagement, assessment & review and home-based care when needed, including doing this with safety in fireground regions and throughout the Covid pandemic era. One core problem is that RANZCP Position Statement on telehealth is still silent on many of these issues, as are the Australian Psychological Society guidelines. [Note attached: Call 4 action with presidents of AMA and RANZCP also being signatories]. Also, we need to compare solely digital practice with digitally enhanced or digitally augmented in-person community mental health practices (See sections 5 and 6 below, plus attached: Rosen A, Gill N, & Salvador-Carulla L, 2020a, and Gurr R. Rosen A et al, 2020, Productivity Commission draft report response-see telehealth sections of both).

As ever, and as with the national mental health response for both Covid 19, the extreme bushfires, prolonged droughts and further inevitably ongoing and compounding climate change emergencies (see invited US psychiatric news articles attached) we will continue to need a careful balance between familiar in-person and outreach home visiting services, delivered with proper safety precautions and equipment, and digital & telehealth services in regional mental health provision.

A message in a recent mass email notification to all health practitioners via AHPRA (10 August 2020) from Professor Michael Kidd AM, the Commonwealth Deputy Chief Officer, states: "Telehealth items are provided on the basis that if a face-to-face attendance with a patient is clinically indicated during a telehealth attendance, then this can be arranged. The face-to-face attendance does not need to be performed by the same practitioner who provided the telehealth service, but providers should ensure that they can arrange a face-to-face attendance if required." This message is encouraging and welcomed by many concerned expert health and mental health practitioners who sent the Call-For-Action document to the Commonwealth on their concerns to re-establish this balance. However, this advice becomes ambiguous, as it is not followed up with any related firm recommendation in the accompanying COVID19 Telehealth Items Guide itself. One partial exception may be the Guide Section 3.4, "In the case of patients living in remote locations, some components could be performed by another service provider (such as a remote area nurse or Aboriginal health practitioner). This might include observing the patient's vital signs, such as pulse, blood pressure and temperature, which could be communicated to the medical practitioner responsible for the service". This is important to state, although it still has too many "could" and "might" qualifiers [See 6.j & 6.k below].

Another promising sign has occurred with the Prime Minister's very recent announcement (Morrison S, 2020) of Commonwealth funding for a new range of clinics and multidisciplinary teams in Victoria, both urban and regional, during the COVID spike there. It includes an undertaking that affected individuals (including Aged Care facility residents) and "their families and carers, will be able to access mental health workers, including psychologists, at these clinics either in person, or via telephone or digital services where needed." Hopefully, their additional capacity to do home visits with safety precautions and equipment, as necessary, will be clearly mandated and properly exercised.

3.   Telehealth Services required for Fireground regions and COVID 19 related mental health services.

My current concerns are for the potential for curtailing or complete withdrawal of these concessional COVID 19 arrangements by 30 September 2020 for psychiatrists and other mental health professionals doing telehealth consultations in parallel with the precedent set last week by the Commonwealth Government withdrawal of nationwide GP Medicare billing arrangements for Telehealth consultations. Also, it is clear that a substantial proportion of fee-for-service psychiatrists doing telehealth now, intend or are likely to revert to their more habitual urban local practices in their rooms when the Covid distancing requirements recede and their own usual clientele return. Also, as stated by Senator Watt in this Senate Hearing 29 July 2020: "One of the things that concerned us was that we were told that, while mental services had been provided on the ground in the early stages after the bushfires—and people were very grateful for that—with the COVID restrictions and the limitations on people's travel, a lot of that face-to-face and on-the-ground service had actually been withdrawn."

There are parallel concerns regarding our prolonged season of extreme bushfires: In particular, the possible transience of the belated replacement of familiar local public mental health professionals on the

ground (whose positions have been depleted by the jurisdictions over years, especially in many of the extreme bushfire-ground regions) by distant telehealth mental health professionals. The consequent risk of having these telehealth arrangements withdrawn by the possible curtailing Commonwealth Medicare arrangements, while the long-term impact of trauma will carry on for many years, may disrupt any prospect of any expert continuity of care.

Several Senators at our hearing expressed similar concerns regarding the uncertainty of Commonwealth telehealth funding arrangements in fireground areas beyond 30 September 2020. However Ms Alison Verhoven, CEO of the Australian Hospitals & Healthcare Association (AHHA) states that: "Health Minister Greg Hunt has also indicated support in principle for telehealth consultations to continue beyond September when the current arrangements expire" (https://protect-au.mimecast.com/s/GEqSCWLVXkUAAZ6pip5Hze?domain=ahha.asn.au).

Previuosly to this Senate committee hearing, I asked Dr Ruth Vine, the Deputy Chief Medical Officer (Mental Health), Commonwealth Dept Health, the following questions:

1.Can you possibly indicate what mental health telehealth and telepsychiatry Commonwealth billing arrangements are being considered for beyond Sept 30th?

2. When do assured rather than discretionary bulk-billing arrangements end for telepsychiatry/mental health professional telehealth sessions for those individuals and families who have been "affected" by the fires and for the fire-fighters and their families?

3. How much utilization over what periods has there been of these arrangements in the different fire-ground regions?

Dr Vine replied that while discussions are ongoing, she was actively seeking further information re issue 3, while issues 1. & 2. are yet to be determined. Issues No.1 and 2. have since been determined, again temporarily, as described in update section.

The Commonwealth Government should still prioritize taking an active role in providing financial signals to work with and incentivize the states & territories to replenish those familiar local teams in more evidence-based and cost-effective ways. This would offer immediate relief for the fireground and badly pandemic affected regions, as well as providing timely pilots for coherent services for the future.

4. Issues for mental health service-users and mental health professions.

a) MH Service Users & Peer Workers:

From: Many Voices, Many Needs: Consultations with people living with mental health issues at the onset of the COVID-19 crisis, Being, April, 2020.
Adapting to new technology: A significant proportion of peer workers expressed a level of difficulty with the move to telephone and online support. Whilst most peer workers are trained to provide face to face support, many are unsure of how to provide such sort through technological methods. Similarly, some peer workers identified that their services were not equipped to provide peer support through digital platforms, leaving many peer workers unable to work in ways other than contact by phone. Further, a number of peer workers were being called on to provide tech support to some of their clients as an added service, despite not feeling comfortable themselves with technology. Some also expressed that they found it difficult to juggle the work of looking after their clients' mental health whilst also providing skills develop in the IT area. Peer workers suggested that some peer workers would benefit from additional IT education themselves if they are expected to provide technical support and/or assist their clients to establish digital and online platforms.
Not being able to provide person-to-person support: This is an area that peer workers are finding particularly challenging when trying to support their clients in relation to accessing

services to meet their clients' needs, such as such as Centrelink, safe housing, and shopping. These kinds of supports are particularly important at a time when so many changes are occurring so rapidly and peer workers felt it important for them to be considered in the same vein as essential clinical services.

Consumer access to technology: Where social groups are moving online, peer workers have experienced challenges because some consumers do not have access to technology, and many peer workers are not trained in such ways of working. Perhaps in some cases, consumers could be subsidised to access technology that would allow them to maintain some level of social interaction during the COVID-19 pandemic. Recommendations for subsidised phones and plans, as well as it equipment and internet plans were highly recommended.

b) MH Professionals:

We mental health professionals, our clinical services and professional organisations need to regain a balance between telehealth /telepsychiatry services and in-person engagement, assessment, outreach & review, with home-based care when needed, including doing the latter with safety in Covid 19 era.   [See attached: Call 4 action]. We also need to liaise with the person's clinicians and family. One core problem is that the RANZCP Position paper and other available clinical professional guidance on telehealth are still silent on many of these issues. This may well pertain also to other professional organisations. See also sole digital practice Vs digitally enhanced or digitally augmented comprehensive community mental health practice (Rosen et al, Future of Community Psychiatry 2020 & Gurr R et al, 2020). TAMHSS response to Productivity Commission draft report 2019).

c) Special Needs populations and culturally appropriate adaptations

For all these levels of service for rural-remote, indigenous, transcultural, refugee/asylum seeker, LGBTI, forensic and aged care institutions and co-occurring mental health and substance using populations and communities, a combination of some in-person and e-health/telehealth "hybrid" services can also provide a range of on-line interim or temporarily bridging partial proxies for the wider spectrum of therapeutic options for rural/remote/indigenous or transcultural populations, which would otherwise only be available in-person at urban or regional centres. (The Orange Declaration, Perkins D et al, 2019, Aust. J. Rural Health).

- **Indigenous communities** are particularly vulnerable to outside visitors or service-providers inadvertently infecting and decimating their elders and others living with longterm physical disabilities, so extra-rigorous precautions must be invoked, and culturally safe solutions should be negotiated in close consultation with indigenous communities. This favours achieving a balance of indigenous community controlled mental health services, which are well-monitored, and offered by local indigenous, trusted, familiar and COVID-safe health and mental health providers for in-person services, augmented by digital services, wherever possible and when appropriate. Opportunities should be provided for a culturally appropriate support person to accompany individuals receiving mental health assessment or support via telepsychiatry or telehealth. Specifically, the offer should be made to the individual and family and then, if they indicate that they want this, involvement should be arranged of an Aboriginal Mental Health Worker or Aboriginal Healer or an elder from their community in any mental health telepsychiatry or telehealth assessment or review. This should always be offered if considering placing the person on an involuntary order, to ascertain whether there is a viable, safe alternative placement or management plan to involuntary care. This is mandatory under the WA Mental Health Act.

- **For individuals living with intellectual and other developmental disabilities**, telehealth may have many potential advantages, including expansion of access when transportation is a barrier and affording convenience and opportunity to observe patients in their own home environment. However, "exclusive reliance on telehealth….can leave gaps in critical aspects of the delivery of appropriate health care for some individuals with disabilities. Limitations in the capacity to adequately ascertain general physical safety and cutaneous manifestations of

disease or neglect (e.g., for patients who cannot verbalize or adequately communicate pain or discomfort) can be significant drawbacks for those who are largely dependent on their own advocacy", (Constantino J et al , 2020) by digital means aided or mediated by a family or employed carer. "Monitoring for adverse effects of medications, such as abnormal involuntary movements, over-sedation, or dystonia, may be similarly compromised in many patients whose caregivers cannot reliably ascertain the presence of these physical states. Gaps in the capacity to communicate with a health care provider that are accentuated in the telehealth context must be recognized and incorporated into risk and benefit appraisals of prioritization for in-person clinical encounters"(Constantino J et al , 2020).

- **The Drought Mental Health Adversity Project [DMHAP]** report 2008-9, under the leadership of then Assoc Professor Paul Fanning, and of which I co-authored the study and sections on impact on Aboriginal communities, DMHAP 2010, Rosen 2009, Rigby et al 2011) was endorsed by government and morphed into a multi-million dollar Rural Adversity Mental Health Program [RAMHP] throughout NSW. Our findings remain relevant that rural and regional Australia required innovative mental health service models to cope with rural adversity from drought/fires/climate change, macro-economic reform and rapidly changing population demographics. A bespoke service model would have incorporated a network of service agencies including local well-trained MH responders, general practitioners backed up by regular and familiar (not interchangeable agency locum) visiting specialists, with access to 24 hour telehealth or telepsychiatry assessments and advice. This could be titrated according to need and locality.

  Complementary findings can be found in the COAG funded Murdi Paaki (2009) and Farm Link (2009) reports that aimed to reduce morbidity and mortality from mental health and drug and alcohol disorders for rural and remote communities, including Aboriginal populations. These initiatives were endorsed by government but not operationalised, despite the overwhelming evidence and support from national advocacy groups (P Fanning, pers.comm.2020, Hart C et al, 2011).

5. Lack of professional organisations providing sufficient routine training and guidance re ethical and more effective practices

All mental health professionals organisations (eg Royal ANZ College of Psychiatry-RANZCP, Australian Psychologists' Society-APS, the Agency for Clinical Innovation and others) need to update their formal advice to all mental health professions on these issues. They variably provide some sound advice on practical matters, including clinical risk and maintaining boundaries, which may also defray some risks for the organisations or professions as well.   There are no or very few recommendations on practitioners trying their best to see ongoing clientele in person from time to time (growing literature on" Hybrid Care" Yellowlees P. et al 2018), nor any insistence on practitioners liaising with the persons' g.p. and with families or local mental health workers or units who/which may be involved, even in crisis, largely because they don't get a fee for these.   So local workers may cop a surprise unheralded emergency presentation because of failure of the telehealth practitioner to communicate such concerns. Some practitioners do try to communicate systematically, but many don't, and there is no formal requirement, nor any real financial incentive, certainly not for psychiatrists, and possibly for other professions. The Commonwealth need to provide financial incentives, ethical and evidence based standard practices (potentially via Australian Commission on Safety & Quality, 2020) & regulatory requirements to ensure that they do so.

6. Mental Health Professionals need guidance & training on how to conduct telehealth, including:

   a. Checking privacy, including who else is in the room or in earshot.

   b.   Welcoming the presence as appropriate, of an existing mental health care coordinator, Aboriginal or transcultural mental health worker or interpreter, primary health practitioner, as well as a family carer or a confidante, if the service-user agrees to or requests it, unless that other person is

actively abusive, threatening or controlling, in a way that would effectively restrict the service user from expressing their concerns.

    c.   Seeking or welcoming co-lateral account or complementary viewpoint from confidante of service user's choice, with permission of service user.

    d.   Routinely consulting and communicating with person's g.p., family or carers, local mental health care coordinator.

    e.   Need to eliminate and/or regulate discretionary or arbitrarily set and charged substantial gap payments.

    f.   If telehealth is employed for ongoing care, it is important whenever practicable, to see them in person, especially in crisis, for initial assessment and annual or comprehensive review, or second opinion. It will usually be understandable if this is not always possible, but it is rarely offered even when it is possible.

    g.   It is preferable for mental health by telehealth practitioners to practice regionally if possible, rather than nationally or beyond, so that periodic in-person reviews become achievable, or so that telehealth practitioners can fruitfully join local team case conferences or reviews.

    h.   Mental health needs in a disaster are often not apparent to some victims until well after the emergency phase and early physical recovery phase, and they may not be ready to reach out or to be receptive to mental healthcare until some months after the height of the disaster, but by that time they often find that the initially responding and offering mental health resource people have left the field and returned to their urban practices.

    i.   While it is appreciated when mental health professionals become willing telehealth practitioners, often from a distance, during national emergencies, it is essential that they make a commitment to continue this service on the same payment basis (eg. bulk-billing) for a considerable time (eg at least for 1 year if necessary with following review) , as trauma precipitated disorders take a long time and consistent treatment to improve and heal. A common complaint in our recent disasters has been warm short-term engagement by professionals who then retract their services and commitment to people from that region. This can feel like a breach of promise, or re-abandonment.

    j.   Services must provide training, updating, up-skilling and regular individual or group supervision sessions for telehealth practitioners, to be arranged and funded via their professional organisation or on an interdisciplinary basis, funded by government.

    k.   Overall, the vast majority of telehealth consultations, particularly by GP's, are by telephone. Practitioners need to ensure that the person is seen in-person if a more comprehensive specialist examination or interactive assessment is required, and if it is too complex to delegate to a primary health care professional. So practitioners must overcome any natural tendency to extrapolate or to resort to their imagination to "fill-in-the gaps" from the limited information or the lack of information available on a telephone or screen. This could occur either in or out of the practitioner's awareness. In extreme form, this could be considered to be professional negligence or could appear to constitute a dysfunctional iatrogenic equivalent of "practitioner confabulation".

    l.   For telepsychiatry/telehealth consultations with rural/remote/indigenous/transcultural communities and populations:

        a.   the practice should be sensitive of the impact of witnessing and recording disclosures made during comprehensive assessment by telehealth and/or emergency management when assessing mental health, sexual & general health and substance issues on patient confidentiality and relationships and fear of public shaming via gossip networks in small communities, and
        b.   practitioners should be familiar with local resources for mental health, sexual & general health and substance use assessment and treatment, and be willing to

actively liaise and to arrange referral to and appointments with these services as needed.

7. Bulk-billing Medicare rebates and gap fees for vulnerable & disaster affected people

We draw on the example of Psychiatry here. Bulk-billing for telehealth and general psychiatric consultations, especially for fireground victims, vulnerable and pandemic affected individuals and families should be encouraged so they will seek mental health services when timely, rather than waiting until they are desperate or actively suicidal. However, the Medicare Schedule needs to be totally revamped if we want to encourage bulk billing, though of course it would cost more and the federal government usually wants Medicare costs to be contained or diminished. We already have the highest out of pocket costs of any OECD country including the USA (for those with insurance) and these services are out of reach for those people with insurance with little disposable income, or those who cannot afford insurance at all.

A problem with advocating for more bulk-billing in psychiatry is that it is so biased towards brief appointments, [maximizing Medicare payment at 4 appointments per hour] and at diminishing comparative rates with less than inflation increases over time. If you only see one or two patients per hour, which may be much more clinically effective, you earn less than if you were salaried in public practice, where you would be paid more per hour plus holidays, benefits and no practice costs. To see a new patient for ongoing care, bulk-billing pays a low fee which is not commensurate with the extra assessment, thinking and writing time required, so private psychiatrists may stick to seeing their habitual clientele or to charging high gap fees, especially for new assessments. While there is a higher paying item (Medicare item 291) for seeing a person for an assessment and preparation of a care plan for the GP to implement, that does not solve the problem for referrals of people likely to need the ongoing skilled care of the psychiatrist (nor the ongoing need to review needs with their family carers). This is not to minimize the problem that, as in other specialties, some practitioners are still allowed to charge exorbitant gap fees on the basis of what the market will bear. Bulk-billing new patients is also problematic, due to the high no-show/last minute cancellation rates, often by those most in need of psychiatric care, which amounts to a waste of time and a loss of income. Medicare should also provide incentives and pay for time spent liaising with the person's gp, family (with permission, currently only in the initial assessment phase at a lower fee), and mental health care coordinator if they have one. Thus, the current Medicare payment system does not effectively shape psychiatrist behaviours in the most desirable and effective directions.

8. Privacy of Personal Information, Security of & Investment in Information Platforms.

As Rosen A, Gill N & Salvador-Carulla L, 2020a, state: There are also concerns on the quality and transparency of the information available to consumers. As stated in a recent Lancet editorial, "without a clear framework to differentiate efficacious digital products from commercial opportunism, the companies, clinicians and policy-makers will struggle to provide the required level of evidence to realize the potential of digital medicine". Unlike pharmaceutical research, there is little disclosure vigilance regarding financial ties and partnership bias in digital health research and it is still possible for researchers, clinicians, and health officers to be investors in the digital products that they are researching and promoting. An improvement of methods of analysis and conflict disclosure is even more pertinent in mental health, where it is necessary to clearly define what kind of players and partners the new digital health companies will be for the mental health community, and how they will 'ensure that mental health data are secure and patient consent for their use and reuse is transparent' without unauthorized disclosure, especially for service users, who are vulnerable and easy prey to public shaming, stigma and discrimination.

9. Current Knowledge & Developments of digital mental health services

9.1. e-Health Mental Health Interventions

Automated digital services can provide a much larger scale of reach at the population level, and can be most effective as primary screening & secondary prevention strategies, and can be very effective as interventions alone, particularly for milder to moderate disorders. This may lower demand for in-person services for milder disorders by GP's, community mental health teams, and private psychiatric and psychology services (Chistiansen H,pers comm). But it could also uncover latent population demand for in-person services for moderate to severe disorders, which cannot be met with existing facilities and workforces.

Mild disorders may respond well to e-health websites, checklists, subjective ratings and therapies, especially with young people, people who are more comfortable seeking services via internet, and those who are shy or wary of personal engagement with service providers. Individuals with **Moderate** disorders may need "hybrid combinations" of in-person, telehealth and on-line mental health services (Yellowlees P & Shore JH, APA, 2018). Whereas, on the basis of intricate modelling algorithms, individuals and families with Acute, **Severe and Complex** psychiatric disorders and severe suicidality usually respond best to inclusive in-person engagement, interpersonal re-connection, interdisciplinary teamwork and assertive outreach (Hickie I, ABC-RN, 1 April 2019, Atkinson J-A, Hickie I et al 2020) with well-coordinated and integrated division of labour, and high level ongoing team support. However, to confidently recommend these pathway distinctions, requires much more empirical evidence.

Rather than the above implicitly stepped-care model, planning for real-world mental health ecosystems requires a more complexity encompassing framework, allowing for multiple variants of face-to-face and digital interactions and settings, with hopefully person-centered clinical and support services (Rosen et al 2020a, Rock D et al 2020). Widening the range of optimal combinations of mental health service experiences for different individuals can be planned for with blended scenarios, rather than "abandoning" mild and common disorders almost solely to e-Health interventions and triage, which may disrupt therapeutic relationships and interactions at and between primary and secondary care levels (Salvador-Carulla L et al, forthcoming study of blended systems). For instance, it is not clearly established that e-health self-help interventions for all mild disorders are superior to and would not be synergised by an in-person therapeutic component if available. For example, on the basis of systematic reviewing of numerous rigorous studies, Cognitive Behavioural Therapies, e.g. for anxiety disorders, delivered by automated computerized delivery service systems may not be as effective as compared with in-person professional CBT services (O'Kearney R et al, 2019), so caution should be exercised before large-scale implementation.

When individuals accessing e-health mental health hubs need escalation for higher severity and acuity, and/or perceived danger of harm, automated escalation is not sufficient nor always reliable or safe. Explicit protocols need to be systematically applied to ensure formal confirmation of acceptance of hand-over of duty of care, at an appropriate level of urgency. This needs to be assured and communicated both ways, verbally and with documentation, between identifiable service provider persons.

Monitoring and management of this and of peak flows of demand for escalation are issues for integration mechanisms between services, including formal service agreements. Public mental health services, and particularly Community mental health staffing levels and mobility, should be reviewed and enhanced to ensure that sustained increases in demands via these portals can be met without being swamped or overwhelmed.

9.2. Telepsychiatry and other Telehealth mental health services

Psychiatrists and other clinicians offering telehealth consultations and advice are best provided in combination and balance with an activated capacity for in-person psychiatric consultations and reviews as necessary, with proper safety precautions. Optimally, the in-person consultations should be provided by the same clinician or team, or by the same rostered and collegiate group of expert clinicians, providing local team and GP consultation, and clinically hand over to each other. Such a combination should provide better engagement, greater accuracy of assessment

and review, better appraisal of physical health needs, better communication and clinical supervision with local GPs and community mental health teams, and better peer review. While telepsychiatry and telehealth counselling are now becoming highly valued components of mental health services for rural and remote communities, they should be part of a mixed and balanced economy or well integrated spectrum of mental health services. It should not be offered as a stand-alone service, particularly in rural settings, without firm Commonwealth, Medicare and RANZCP requirements to act in close and regular clinical communication with GPs, community mental health teams, and families, especially if agreed by the initial service-user. It is often community mental health teams who have to deal with ensuing crises and acute admissions, sometimes by complete surprise, as telehealth practitioners are not required to do so, and nor are they separately reimbursed for such regular communications.

9.3. Limits to our Knowledge and Understanding, or "Known Unknowns":

We are beginning to know how much we don't know in the fields of applying e-health and telehealth. We are realizing that clinicians conducting telehealth practices need to acquire different skill-sets for:
a) competence and reliability in early prevention and detection, triage, referral, assessment, clinical advice, counselling, treatment, and review via e-Health and Telehealth, and/or in their use in augmenting in-person practice,
b) establishing organisational or business models to sustain them, and
c) anticipating and understanding the many complexities, including transience of services and variable equity of access for and use by vulnerable populations , of e-Health and Telehealth service delivery, as demonstrated by the rapid shifts to digital services, accelerated by the sudden demands of the extreme bushfires and the pandemic (Taksa L, pers.comm.2020, Erfani S S, et al 2016)).

10. Conclusions & Recommendations: On-line Mental Health,Telepsychiatry & Telehealth In Balance with Local Mental Health Services:

1. **a) e-Health:** Judicious bringing to scale and use of firmly evidence-based e-Health initiatives, especially for the growing more receptive segments of Australia's population, should be planned for as part of a blended mental health ecosystem framework, in balance with in-person services. However, we must not generate demands, nor raise expectations that we can't meet via on-line mental health portals or by any other means.

    For escalation or urgent triage of symptoms rated as severe and risking life by on-line scales from automated e-health systems, it is unacceptable to escalate or refer such individuals by automated call, text or email, lest the receiving service is depleted and way behind in opening messages. Explicit protocols need to be systematically applied to ensure formal confirmation of acceptance of hand-over of duty of care, at an appropriate level of urgency. Such referral needs to be assured, confirmed and communicated both ways, verbally and with documentation, in-person between identifiable human service providers.

1. **b) Telehealth:** Medicare subsidized telepsychiatry and mental health professional telehealth, where needed for the regional mix of clinical mental health services, could be jointly monitored and regulated between the Commonwealth and State or Territory Governments via a jurisdictional budget-holding and "Commissioning" Mental Health Commission (eg W.A.), or Regional Commissioning Authorities. These could protect and pool mental health service funding from all public sources, as recommended by the Productivity Commission [Gurr R et al, response to draft Productivity Commission report, Jan 2020]. Under these provisions, telehealth practitioners should be obliged and incentivized to:

    *   encourage longer consultations where needed, and regular liaison with the person's GP, with their families (with permission of the service-user), and with Community Mental Health teams, especially if there is any risk of presentation to public services.

- be governed by a single or unitary and widely agreed regional MHS plan integrating all public, NGO and any privately contracted MHS. This plan should have some formal obligation status such as strictly operated contracting, with clear sanctions, rather than just a loose in-principle service agreement.

These arrangements could underlie a regional "arm's-length" commissioning method of ensuring delivery of contracted services, whether from public, NGO, private institutional or fee-for-service sectors, with monitoring and auditing of both budgets and expenditure acquittals to ensure that no shifting of resources to non-contracted or non-MHS services, or funding will be promptly withdrawn.

2. The Commonwealth should provide more easily accessed e-Health portals and telehealth augmented services which have been fully determined to be cost-effective, to help to meet the growing surges of demand for mental health services generated by recent prolonged disasters, and beyond.

3. As digital communication and telehealth are used more by clinical, rehabilitation and support services, service users, peer workers and families need technical education and support for less technologically literate individuals and families, to ensure that lack of familiarity with technology does not exclude them from online clinical and social support services and opportunities for sustained social contact. The latter is therapeutic in itself. Provision of funds is needed to purchase hardware and connectivity for people living with mental health issues who are not currently able to afford them. Provision of IT familiarization and ongoing technical support is also required (Being, 2020). However, service users who are isolated, whether due to their disabilities or environmental adversities and disasters or both, will need all this in balance with safe and regular in-person contact.

4. <u>Finally, the Commonwealth Government has a crucial role and an overarching responsibility to ensure a fully functional balance between distal digital, office based and local familiar in-person and assertive outreach services for all vulnerable Australian populations, whether their vulnerability and adversity is due to extreme bushfires, prolonged drought, floods or pandemics, climate change, and other social and cultural determinants, including indigenous, rural-remote, migrant and forensic communities.</u>

- The Commonwealth government needs to work with the states and territories to enhance funding, not just for e-Health, telehealth and for increasing the number of Better Access sessions, but also for adequate provision of local, familiar, in-person, community outreach, inpatient and hospital-in-the-home alternatives and other community-based rehabilitation and supported residential facilities.

- The Commonwealth should urgently take an active role in work with, provide financial signals to and incentivize the states and territories to replenish depleted local community mental health teams, restructuring them in more evidence-based ways of operation. This would offer immediate relief for the most vulnerable fireground communities and both badly and as yet only moderately pandemic-affected regions, as well as providing timely pilots for coherent, cost-effective services for the future.

- The emerging National Safety and Quality Digital Mental Health (NSQDMH) Standards (ACSQHC, 2020) should be welcomed, but need strengthening by providing more explicit expectations and guidance to effectively shape or monitor the ethical behaviour and evidence based practice of Australian practitioners and mental health service systems. Hopefully, these will emerge in their ultimate versions.

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