TAMHSS

Transforming Australian Mental Health Service Systems

Developmental Trauma Service Proposal 12-25 Age Group

August 2018

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There is strongly emerging evidence that developmental trauma, otherwise known as Complex Post-Traumatic Stress Disorder, is very prevalent.

A national study in England in 2013 found that almost half the general population reported at least one adverse childhood event and over 8% reported four or more (Bellis et al, 2014b). Other studies consistently estimate around 12% or more have significant levels of childhood trauma. At least one in four children have experienced child abuse or neglect (including physical, emotional, and sexual) at some point in their lives, and one in seven children experienced abuse or neglect in the last year (USA Centers for Disease Control and Prevention).

Developmental trauma should not be conflated with PTSD, which is a sub-set of symptoms in a wider range of deleterious effects of developmental trauma, including depression and self-hatred, anxiety, dissociation and depersonalization, aggressive behaviour against self and others, problems with intimacy, and impairment in the capacity to experience pleasure, satisfaction and fun. Effects are "dose" related and cause much personal pain, chronic health disorders, early death and societal disturbance. There is a massive whole of life personal, social and economic cost to society, but this is not being effectively addressed.

Technology has enabled us to measure protective, evolutionary adaptive, plastic changes to the brain in traumatised children, which help their survival in childhood, but which become maladaptive in adolescence and adulthood. Technology is now helping us understand the functional effects of these changes and thus find ways of re-training the brain to function normally. Developments in psychotherapies are becoming more effective, especially after brain re-regulation.

With over 30 years of experience, treating thousands of traumatised refugees of all ages, the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) is seeing very positive outcomes. For example, highly traumatised former child soldiers from Africa have been able to settle in class and complete their education with modern therapies. These learnings need to be implemented for the general population.

Why Now?

Over the last 5 years, testimony given to The Royal Commission into Institutional Responses to Child Sexual Abuse has brought to public attention the lifelong pain, suffering and disabilities created by child sexual abuse. While the issues dealt with have only been the tip of the iceberg of developmental trauma, it has created an expectation that governments will do something to provide compensation and to prevent future trauma.

However, financial compensation will not provide the treatment that trauma survivors desperately need, and the Royal Commission recommended significant investment in effective treatment, and this proposal would be a highly relevant implementation of highly promising treatment modalities, which would also benefit from further replication on an implementation science/cost benefit basis.

The progress in understanding brain development, plasticity and function over the last few of years is now leading to new insights into designing innovative treatments that include brain training for re-regulation and go beyond previously best practice psychotherapies.

With the clear evidence of need and the massive cost of not acting (see below), it is timely now to systematically invest in emerging effective treatments and prevention.

Why 12-25 age group?

Treating developmental trauma can be divided into four natural segments:

Becoming Parents

Developmental trauma can be passed from generation to generation. Parents who have been traumatised as children are much more likely to traumatise their own children. They can be identified at the time of pregnancy, delivery, or child infancy, and an active program to effectively treat (not just support) parents, would be a primary prevention for their children.

Infancy & Childhood

Preschool to end of primary school/puberty, developmental trauma could be identified by teachers trained to do so and families referred to a trauma treatment service. Traumatized parents, missed earlier in the child's life, could be also be identified by other services (mental health, alcohol and other drug services, police, child at risk services etc) and receive treatment for their own developmental trauma or later onset PTSD. Proactively seeking and treating these parents is important in limiting the damage to their children.

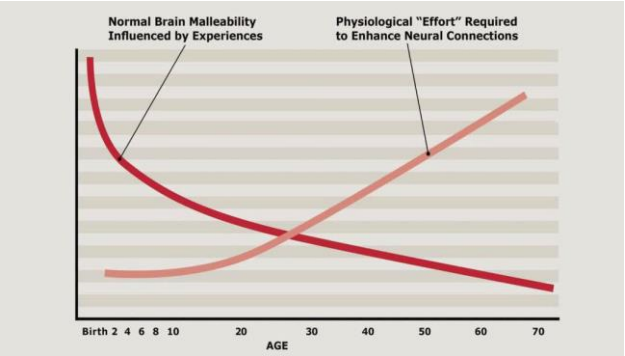
The children also need treatment, whether remaining with their parents or in out-of-home care. These services need particular child and family therapy skills, as the parents are still the main influence and carers for children, and attachment issues must be addressed.

Adolescence & youth (12 -25)

This is the period of maximum emergence of mental health disorders, as the brain prunes connections for efficiency, but exposes functional problems when the most demanding developmental changes are faced, from sexual maturity, peer social competition and the emergence of an independent self. Many studies consistently show childhood developmental trauma creates high vulnerability and adverse outcomes in this age group.

Thus it is a period of high risk, with high levels of stress, social experimentation that can fail, high anxiety, self-medication with illicit drugs and alcohol, depression, self-harming and suicide, and involvement in the criminal justice system.

Behaviours displaying distress become more visible and effective recognition and treatment will have a life-long benefit, as the brain is more easily re-regulated in this period. Treatment should in turn protect their children, and stop the transfer of trauma to the next generation. The return on investment will be very high in this age group.



Adults

Over the age of 25 there is a different mix of trauma experiences – still very many untreated for developmental trauma, but also additional traumas from single traumatic events or multiple events, such as PTSD in soldiers. There is clear evidence that it is not too late to apply brain training and new treatments.

All of these phases need expert specialist services to provide leadership to effectively treat the range of responses to trauma.

Types of Trauma

- Neglect - Parental absence both physical and emotional
- Emotional - Parental psychopathology, intoxication etc
- Violence, direct and vicarious (domestic, community, school, disaster, refugee etc)
- Sexual abuse - Incest, family associate, external perpetrator, opportunistic rape
- Accidental e.g. MVA's sport & recreation, war injury etc
- Single event versus multiple events versus developmental – 3 basic types that can overlap
- Vicarious

These types should not be conflated, as they each cause different changes in the brain and need different treatments. The same traumatic event can result in very different brain responses based on individual factors. Many have parental attachment disorders and/or dissociative responses that require longer term psychotherapies or somatic therapies.

Effects of Developmental Trauma

An important review of all the developmental trauma brain imaging studies, up until publishing in 2016 (Teicher & Samson), showed consistent evidence of brain changes compared to healthy controls, due to the different types of trauma. A lack of understanding of the effects of these changes has caused errors in diagnostic formulations based on symptoms alone, and failure to treat these evolution driven, adaptive changes, leads to poor outcomes with mainstream therapies.

For example, trauma could have occurred in a preverbal developmental phase e.g. infancy, before the person had words to express their experience, or the stress of the trauma can cause the language areas of the brain to shut down (not needed to fight or run away), so little language based memory is stored, and the person cannot give an articulate story about what happened. Psychological protective mechanisms, such as dissociation to block the conscious mind from feeling the trauma, can remain until actively assessed and treated.

Much of the memories of trauma are stored in the parts of the brain and body that defended against the trauma, which is why body based therapies can be important.

The brain controls our bodies, and trauma thus has effects on many physical health management systems, such as the autonomic nervous systems, hormones, bio-rhythms, sleep etc. There is now consistent evidence of the massive detrimental effects that developmental trauma (and later life trauma) has on our physical health. For example, Prof. Anthony Broe (NEURA) recently reported a strong correlation between early dementia and high scoring on the Childhood Trauma Questionnaire. Trauma causes accelerated ageing by shortening telomeres, which may be reversed by control and reduction in stress, regular exercise, anti-oxidant diet, meditation and yoga.

A large longitudinal prospective study, assiduously following up 1,037 consecutive births in Dunedin hospital for 45 years, has shown that, assessed at the age of 3, a segment with Low Socio-Economic Status, Child Maltreatment, Low IQ or Childhood Low Self Control, comprising 22% of the cohort, accounted for about 80% of social and economic costs by the age of 38. 12.7% had received a diagnosis of PTSD by age 38, and that would not include the other types of trauma responses.

36% of the cohort's injury insurance claims
66% of welfare benefits
40% of excess obese kilograms
77% of fatherless child-rearing
54% of cigarettes smoked
78% of prescription fills
57 % of hospital nights
81% of criminal convictions

The Centers for Disease Control and Prevention in the USA have a website dedicated to this issue, with a huge collection of scientific papers supporting the whole of life effects on all aspects of health.

Why Invest in Developmental Trauma Treatment?

Australian Pegusus Economics in 2012 estimated that, if the impacts of child abuse (sexual, emotional and physical) on an estimated 3.7 million adults are adequately addressed, the combined budget position of Federal, State and Territory Governments could be improved by a minimum of $6.8 billion annually. In the population of adult survivors of childhood trauma more broadly, i.e. a figure of 5 million adults, this estimate rises to $9.1 billion. On different, but plausible assumptions, the annual budgetary cost of unresolved childhood trauma could be as high as $24 billion.

Access Economics took a slightly different approach in 2007, and estimated that 177,000 children under the age of 18 were abused or neglected in Australia that year. This figure could be as high as 666,000 children and young people. Based on these numbers, the best estimate of the cost of child abuse incurred by the Australian community in 2007 was $10.7 billion, and as high as $30.1 billion.

They also estimated the lifetime cost of child abuse to children abused or neglected for the first time in 2007, which were between 130,237 children and as high as 490,000 children, finding the cost to be$13.7 billion, but could be as high as $38.7 billion, in 2007 dollars. USA cost estimates are consistent with these estimates. Globally we must find better solutions to reduce the personal, social and economic costs!

Effective investing in developmental trauma treatment could be the greatest single public health initiative of all time.

Targeting some initial investment at the 12- 25 age group will give the fastest results, as they are looking for solutions now, before maladaptive behaviours become embedded.

This proposal is consistent with the Phoenix Australia and Orygen policy document "Trauma and young people", operationalising its principles and suggested practices

Why a Specialist Service?

Experience at STARTTS has shown that training health disciplines through theory courses, over almost 30 years, has not been effective. There are team and individual fears of kindling vicarious trauma; a lack of thorough practical skills training and ongoing supportive and expert supervision; practice isolation of a sole skilled trauma practitioner among generically skilled staff; and the lack of service support for treating developmental trauma. It takes skilled consistent care for the individual and months to years of time. There are very few courageous clinicians actually treating developmental trauma!

The historical funding methodology, of fee-for- service private psychotherapy practice, with limited sessions, limited time per session, lack of support for training and ongoing supervision, is not evidence based and not effective, as stated in the Royal Commission report. A major study in the USA showed that it was impossible to achieve best quality and efficiency in mental health services with this fee-for-service method. Also, the services funded following the report are for adults, only targeting a small segment of those with developmental trauma. With many questions still needing to be answered, only properly structured, dedicated services, with motivated leadership, an evidence base, high intensity of care and an active response team culture, will bring optimally effective results.

A recently published meta-analysis (2018) of 25 studies, where the people attending specialist mental health services were screened for post-traumatic stress disorder, showed an average of 33% met criteria for PTSD (e.g. substance use 36%, psychotic 31%, affective 39%). However, only 2.5% of case notes mentioned the fact. If they had also screened for developmental trauma these figures would have been higher. This illustrates the lack of understanding about developmental trauma and how to treat it in mainstream specialist mental health services. A new specialist service needs to have capacity to treat co-occurring mental health disorders, either directly or through treatment partners.

The next generation of clinicians need an effective training environment and case-based learning with intensive supervision, and this will only happen in a specialist service set up to do so.

Currently a lot of money is being spent by state and federal governments on programs for disturbed youth, but they are piecemeal, focussing on small pieces of the jigsaw, such as suicide, other self- harming, substance abuse, criminal activity, homelessness, personality disorder, anxiety and depression etc, when the major underlying cause is developmental trauma. While these services try their best, they do not have the means or skills to effectively address the trauma.

This program would work in close collaboration with all the agencies working with young people, to provide the specialist treatment to their clients, while also supporting their staff to provide trauma informed care.

Recommended Evidence Based Interventions

There are 21 highly endorsed consensus clinical guidelines, that have been compiled from the extensive literature and set out in the 'The Last Frontier' – Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery, published by the Blue Knot Foundation. These are also elaborated in the "Trauma and young people" policy document published by Orygen & Phoenix Australia.

It is acknowledged that there are many gaps in knowledge and the quality of evidence, but that is even more reason to create some specialist services that systematically address these issue, rather than wait for the haphazard academic process to fill the gaps. It is assumed that these guidelines will be implemented by services funded under this proposal. In summary, key components include:

- Assessment using validated tools and interviews
- Creation of a safe environment, engagement and therapeutic relationship
- Psychological education about trauma and its effects
- Brain regulation;
  - Repair plastic adaptive responses to childhood trauma, done in combination with individual psychotherapy (Neurofeedback, EMDR, Tapping, Heart rate variability etc.)
  - Group methods – e.g. Trauma Sensitive Yoga, Capoeira Angola, Mindfulness
- Talking therapies;
  - Attachment therapies – one to one (e.g. Conversational Model)
  - The many variations on Cognitive Behaviour Therapies, both individual and in groups
  - Other psychological frameworks (e.g. Narrative Therapy, Internal Family Systems)
- Family Therapies - where appropriate
- Other group therapies (e.g. psychodrama methods, self-defence classes)
- Somatic therapies (e.g. massage, sensory)
- Social connection groups
- Completion of adolescent and young adult developmental tasks
  - Complete education – Education Support Program
  - Obtain appropriate paid work – Individual Placement and Support program
  - Learn skills for appropriate intimacy - Strongest evolutionary driver to produce the next generation, so only feel complete with a sexual partner
  - Health lifestyle, diet and exercise

It is necessary that there is a wide selection of treatments available, due the wide variety of phases of development, individual needs and social environments. An efficient approach will be to develop a hierarchy of treatments, from the more generic to the more specific and individualised, but there will be the need for one to one case management and psychotherapy for all in this age group.

To provide the required range of services, there must be sufficient volume and critical mass for efficiency and sustainability.

Eligibility Criteria

Considering the high prevalence of developmental trauma, there will be a need to give priority to the more severely affected. Expert advice will be sought on screening, assessment and decision support tools. The number of people that can be treated per year and the size of population that can be covered by this service design is hard to estimate at this time, but will become apparent with diligent data collection.

Service design

Components of Care

- Comprehensive assessment, diagnosis and formulation, including QEEG where possible
- Physical health assessment, treatment and monitoring
- Case Managers/psychotherapists with case load no greater than 15- 20 per fte, with average weekly treatment ranging from 6 months to 2 years (with extension based on need), with unlimited treatment sessions (team supervised for appropriateness). Experience shows clients cease treatment when ready, as they are more interested in getting on with life, whereas set therapy time limits lead to anxiety about separation from the therapy service and can delay progress.
- Regular team case review meetings for support, risk management (higher suicide, violence, health risks), teaching, monitoring of client progress, client flow and demand management.
- Functional Recovery staff providing a hierarchy of therapies that improve brain regulation social connection, and psychological meaning, including:
  - Trauma sensitive Yoga
  - Bodywork (including massage, sensory and other somatic therapies)
  - Capoeira Angola (an enjoyable group activity requiring mindfulness and controlled social interaction, found useful for brain regulation at STARTTS), with music.
  - Art Therapy for those less able to verbalise
  - Drama Therapy; self-defence classes for those physically or sexually assaulted.
  - Healthy lifestyle – diet and exercise
- Access to alcohol and other drugs specialists, but treatment integrated with core psychotherapy, as it is so commonly a factor.
- Specialist staff providing education completion support and employment services.
- Encourage the development of communities of peer support, as the effects of developmental trauma can be long lasting and fluctuate with changing circumstances.

Delivery Vehicle Design

- Easy non-stigmatising access, such as co-located with primary care headspace sites. As with the headspace Youth Early Psychosis Program, this could add depth to the headspace model, and there can be better critical mass and efficiency for shared group programs and facilities. Could be across two headspace sites for ease of access.
- Must be able to provide mobile outreach and home-based assessment and care.
- Extended hours of operation for convenient access.
- Specialist teams for fidelity to the model, staff support, training and supervision.
- Must have psychiatrists for strong diagnostic reliability/ fidelity & capability, due to high levels of overlapping disorders, from anxiety, depression, substance abuse, psychosis, neurological disorders, chronic pain and other somatic disorders and for comprehensive individual care planning and implementation.
- Must include teaching and strong supervision capabilities, to include undergraduate and postgraduate students and workforce development.
- Designed and resourced to support external clinicians (psychiatrist, GPs, psychologists and other allied health) in surrounding areas and youth agencies, through continuing education and direct consultancy services for case-based learning and support.
- Must have team critical mass for sustainability, attraction of quality staff, efficiency in the use of specialists, and staff turnover management.
- Must include staff with lived experience.

- Must include staff from indigenous and culturally and linguistically diverse backgrounds for cultural inputs.
- Staff salaries and conditions must at least be equivalent to the relevant state LHD staff awards and staff contracts must be a minimum of 4 years to enable staffing stability and the development of expertise through case-based learning and supervision (like an intern arrangement, as expertise is rare). It takes a long time to get a specialist service such as this recruited, and to a steady state of functioning, with many systems to be developed.
- Active demand management and work flow processes – there will be a lot of demand based on the high prevalence of young people affected by developmental trauma and the need for sufficient time for therapies.
- Active awareness raising, community education, community engagement and advocacy.
- Must include the infrastructure and staffing to build in comprehensive data collection, evaluation and research, so that it is an inalienable function of the whole activity.

Staffing Structure

- Service Director with relevant dinical background
- Clinical Director Psychiatrist – full time – quality of care, evaluation/research, clinical risk
- Psychiatrist – full time – diagnosis and psychiatric treatments
- Senior Clinical Psychologists x 2 – training coordination/supervision/limited direct clinical
- Therapy Team Leaders x 2 – limited direct clinical20 psychotherapists (mixed disciplines, diverse backgrounds)
- Functional Recovery Team Leader – group work coordinator, other therapies coordinator.
- Functional Recovery Staff – 6 fte including education support specialist, employment specialist, exercise physiologist, dietician, physiotherapy/massage, Capoeira trainer, trauma sensitive yoga therapist, Art Therapist, therapy group leaders.
- Community Liaison/Education/engagement Officer
- Intake/Work-Flow Coordinator
- Intake clinicians/waiting list management x 2
- Data and Evaluation Coordinator
- Psychiatry Registrar – full time trainee
- General Practitioner – 0.4 fte for those at health risk and who will not attend an external GP
- Quantitative Electroencephalography (QEEG) Technician - full time
- Administration Manager – finance/logistics/ facilities etc
- Clerical support/Reception/data/evaluation support – 3 fte
- Space for visiting external research and evaluation project staff
- Contribution to organisational overheads – HR, payroll, IT support, etc.

Program Governance

Rapidly developing knowledge, so need to build in quality program governance to allow for rational informed changes to the program over time. We can base the program on best available evidence, but there are clear knowledge gaps and we need to let a variety of interventions be tried and tested. We need a national expert committee (academic researchers, service delivery management experience, consumers) to provide ongoing advice to the Commonwealth, PHNs and delivery contractors, wanting design changes based on emerging evidence.

Prospective Research and Evidence Development

Controlled research in this area is not easy, due to many variables, therapy processes take a long time and the whole of life rewards for investment will not be fully known for many years. The hypothesis is that benefits will be seen across a wide range of health, social services and employment outcomes. Thus there is a need for both quantitative and

qualitative research and evaluation, with long time lines that do not meet the usual criteria for various national research funding mechanisms and which also do not sit well with current academic performance demands. Funding should be included so that research and evaluation can be commissioned, so that several projects can be carried out at the service or across services.

- Long term funding and contracts to enable prospective studies.
  - Academic Connections, but not university controlled
  - Commissioned research to answer key questions
  - Action Research/implementation/ triangulation research methodologies.
- Research Network, with de-identified data sharing, to enable comparisons of different interventions and sufficient numbers for statistical power.
- Developing a national clinical database will be essential. Training and Development Roles

Having pilot services progressively funded in each state would enable cross fertilisation and the bases for extension across the community, through education and supervision of developing treatment clusters. This proposal is aimed at getting the program started with clinical action and evaluation, but teaching and supervision is also time consuming and further staff and funding would be needed.

Funding Model

Reality of funding sources – the Commonwealth Government is the obvious best source of funds for this program, due to the fiscal imbalance in the Australian federation (Commonwealth receives around 82% of taxes and the states only 18%, but the states need about 40% to provide public services). There are current funding risks in the states, with significant diversion of funds from community based mental health services to acute hospital care. However, this is not just a mental health program – it is aimed at investing to reduce expenditures, over the whole of government, over the whole of the survivor's life and the next generation.

Block funding initially – hybrid funding potential, but Medicare fee for service design would need considerable changes to match the natural history of effectively treating developmental trauma, especially attachment repair. Current experience with activity based funding for community based mental health services, shows only historicalgeneric services (no evidence based models of care), are being costed as the basis for funding. This would not be a rational basis to fund this necessarily initial specialist model.

As a specialist program, there needs to be expertly designed commissioning contracts, and Primary Health Networks can only develop the commissioning skills with advice from the expert committee. Contracts need to be for a minimum of 4 years, and preferably 5 years, with guaranteed rollover if performing as expected, as the short term nature of recent mental health related contracts via PHNs have strongly inhibited implementation of complex clinical models of care (e.g. Early Psychosis Youth Service) The Commonwealth needs to change its funding methodology for this specialist clinical service, to factor in professional staff state-based remuneration and conditions variations, incremental payment scales and inflation, in order to meet the market to attract and keep staff. The current allocation of initial funds, with no increases to provide for these factors, leads to program instability and deterioration, due to loss of trained and experienced staff over time (not meeting the market for their desirable skills), loss of staff FTE, and loss of quality (if time per consumer rationed). There can be high turnover of junior staff, who join to get training and then leave for higher pay, so expertise does not accumulate and the quality of the interventions dissipated. Finding efficiencies in service delivery should be evidence based, rather than the Commonwealth progressive erosion method.

- Funding for equipment, such as QEEG and neurofeedback, to be included.
- Funding for training and supervision by external experts should be included.
- Vehicles will be required for home visiting and group transport.

Fifth National Mental Health and Suicide Prevention Plan

This proposal would make a significant contribution to the Plan, as developmental trauma is a major factor leading to suicide, Aboriginal and Torres Strait mental ill health, more severe mental illness and poor chronic physical health. It will improve system performance by integrating evaluation and research with service delivery and targeting research to answer important questions. At the time of implementation, consumer involvement in local co- design would be important.

National Alcohol and Other Drugs Strategies

As people with developmental trauma have very high rates of self-medication with tobacco, alcohol, cannabis, opioids, amphetamines and over the counter medications, effective treatment of the underlying causes should be taken into account in Due to the high levels of unhappiness and anxiety, they are often diagnosed with depression and prescribed antidepressant and sedative prescription medications, which are of marginal benefit. These simplistic and expensive attempts at symptom control are not curative, whereas brain re-regulation and targeted best practice psychotherapies can be curative and a lot cheaper over time.

Program Risks

Conflicting messages and unrealistic KPIs in contracts between layers of commissioning (Commonwealth Department – Primary Health Network – Non-government Organisation).

Funding and contract uncertainties, leading to staff anxiety and exit stampedes, followed by having to rebuild, when greater funding certainty is restored.

Commonwealth government expectations that quality staff will accept a discount in pay and conditions to work for an NGO (large differences in state markets – one size does not fit all).

Failure to sustain the program by death by a thousand cuts (e.g. no inflation adjustments).

Future Vision

If we are to follow the evidence, programs such as this need to be rolled out to cover the whole population, whether urban, regional or remote, with variations for language and cultural needs.

Initially it would be good to fund pilot services that can trial adaptations to fit particular communities across the nation. Highest demand is likely in the lowest socio-economic areas.

While many parents and families, of dependent adolescents and young adults living with developmental trauma, will be offered therapy in connection with the traumatic disorders of their offspring, this will not always be appropriate. This program is aimed at the youth age group, but the other age related segments, discussed above, also need targeted programs and funding. New models of care should be established for those needs, with expert advice and funded concurrently, or as an extension of funding over time. Technology may enable services for remote communities.

Conclusions

We have opened our eyes through the Royal Commission.

We have reached a tipping point in our understanding of the effects of developmental trauma on the brain and some techniques to provide effective care.

Now we need the courage to seriously invest in a journey to implement the knowledge we have, but to do so with open minds for innovation and systematic evaluation of choices.

In medicine it often takes 10-30 years to implement new evidence – what a national shame if we delay this opportunity to heal individuals and communities.

Decisions to invest should not be driven by the cost of the investment, but by the heavy cost of inaction, of not investing as soon as possible.

Act now and imagine how good you will feel if you help to bring this service to fruition!

Bring your support to the attention of decision makers NOW, politicians and senior public servants, across the many relevant government departments.

Transforming Australian Mental Health Service Systems (TAMHSS) was formed in 2009 at the Perth TheMHS Conference

TAMHSS Network recognises the cultural diversity of the many Australian communities, and the importance of engaging them in awareness of their own mental health and prevention and early intervention of mental illness, related stigma and discrimination. We also recognise the many special needs for services to deal with complex disorders.

THE OBJECTIVES OF THE TAMHSS NETWORK ARE TO:

1. Provide a means for the Australian Community to become involved in the transformation of our mental health service systems.
2. Promote the rights of all consumers and families to receive services they need.
3. Promote a wide and consistent range of high quality mental health services across all age groups and throughout the country.
4. Promote interventions which are based on best practice as determined by both quantitative and qualitative evidence.
5. Promote a service delivery system that is integrated at every level including participation of all service sectors (public, private & NGO).
6. Promote the right of equity of access to all.
7. Promote a regional funding system and methodologies that provide adequate quality, control of both budget and expenditure, and transparent accountably, all of which should be independently monitored.
8. Promote recovery-oriented service systems which focus on the goals of social inclusion and citizenship.

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21 August 2018